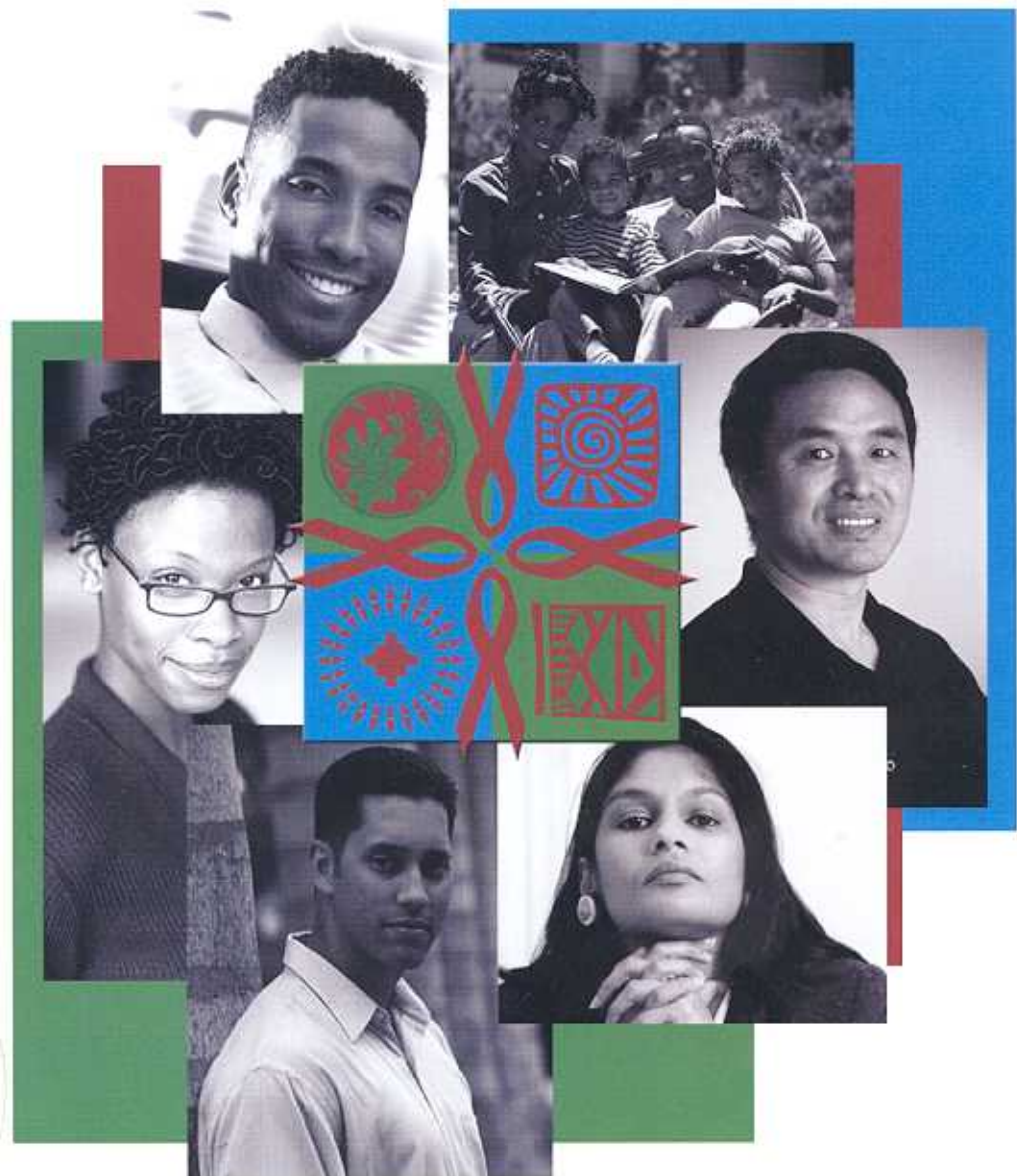
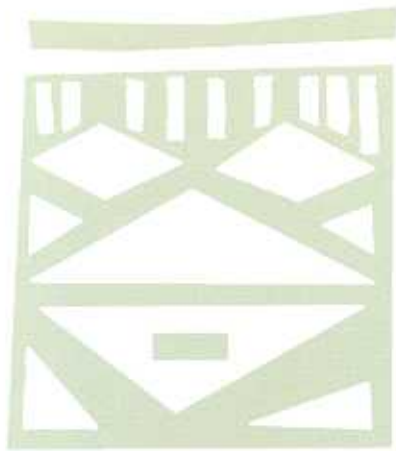
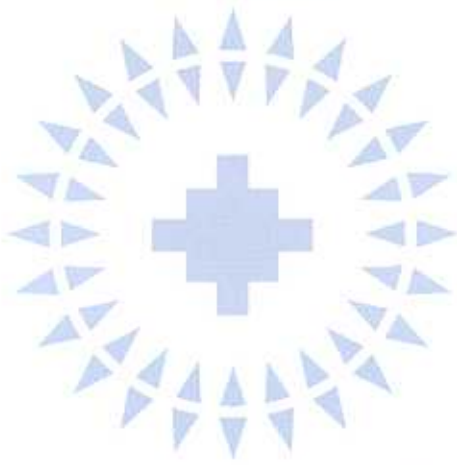


HIV/AIDS

AMONG MINORITIES

IN GEORGIA

2003



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH





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Background of HIV/AIDS

What is HIV/AIDS?

The human immunodeficiency virus (HIV) is the virus that causes AIDS¹. The acquired immunodeficiency syndrome (AIDS) was first identified in the United States in 1981 and is an epidemic around the world².

AIDS develops when the immune system of an HIV-infected person gradually deteriorates leading to severe debilitating conditions².

What is the worldwide and national impact?

As of December 2001, there are 37.1 million adults and 3 million children younger than 15 estimated to be living with HIV and AIDS worldwide³. Of the 37.1 million adults living with HIV and AIDS, 50% or 18.5 million are women. In 2001, there were 3 million AIDS related deaths worldwide. Approximately 95% of people with HIV live in the developing world.

There is an estimated 800,000-900,000 people living with HIV in the United States². By the end of 2001, approximately 363,000 persons are living with AIDS in the United States³. As of December 2001, there were 816,149 cases of AIDS and 467,910 AIDS deaths reported in the United States. Among persons living with AIDS in

the United States as of December 2001, 42% are African-American, 37% are white, 20% are Hispanic/Latino, 1% are Asian/Pacific Islander, and <1% are American Indian/Alaska Native.

Of the estimated 40,000 new HIV infections each year, 70% are in men and 30% are in women⁴.

How is HIV transmitted?

The most common mode of transmitting HIV is through unprotected sexual contact with a person with HIV⁵. HIV enters the body through the lining of the vagina, vulva, urethra, rectum, or mouth during sex. HIV is transmitted among injection drug users by sharing needles, syringes or drug paraphernalia contaminated with HIV-infected blood. The virus was spread by transfusions of HIV-infected blood or blood components before donated blood was screened and before blood products were treated to destroy HIV⁵. It is now extremely rare for HIV to be transmitted through transfusions of blood or blood components. It is rare for a patient to infect health care workers or for a health care worker to infect a patient through contaminated needles or other medical instruments.

If a pregnant woman with HIV is not treated with

medication, there is a 25% to 33% chance that she will transmit the virus to her baby during pregnancy, after giving birth or through breast-feeding⁵. Treating the mother with multiple drugs greatly reduces the risk of HIV transmission to the baby and delivery by cesarean section may reduce the risk further.

There is no evidence that saliva, sweat, tears, urine, or feces transmit HIV⁵. Mosquitoes cannot spread HIV. Casual contact such as sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats does not transmit HIV. HIV transmission has been documented in persons whose only acknowledged risk behavior is performing oral sex. The risk associated with oral sex appears to be much lower than with genital or anal sex, but it is a recognized mode of transmission.

A person with a sexually transmitted disease such as syphilis, genital herpes, chlamydia, or gonorrhea who has sex with a person with HIV is more susceptible to HIV infection⁵. A person with HIV and another STD is more likely to transmit HIV.

The risk of HIV infection is greatly reduced if high-risk behaviors such as unprotected sex and sharing needles infected with HIV are avoided.

What is the progression of the infection?

In the early course of HIV infection, many people will not develop symptoms⁵. However, flu-like symptoms such as fever, headache, tiredness, and enlarged lymph nodes (immune glands in the neck and groin) may develop within a few months of exposure. This illness generally lasts a week to a month and is sometimes mistaken for the symptoms of another viral infection. It may take 10 or more years before the more persistent and severe symptoms of AIDS appear⁵. This is the highly individual "asymptomatic period" where CD4 + T cells, which are part of the immune system, are being destroyed. CD4 + T cells or "T-helper cells" are immune cells that fight infections in the body. The following symptoms will often appear during the months or years before a person with HIV develops AIDS⁵:

- Lack of energy
- Weight loss
- Recurrent fevers and sweats
- Yeast infections (oral or vaginal)
- Persistent skin rashes or flaky skin
- Non-responsive treatment to pelvic inflammatory disease in women



Background of HIV/AIDS (continued)

- Memory loss (short-term)
- Frequent and severe herpes infections
- Slow growth or recurrent sickness in children

The Centers for Disease Control and Prevention (CDC) is responsible for HIV/AIDS surveillance in the United States and providing a standard definition of HIV and AIDS⁵. A person with HIV infection is diagnosed with AIDS, the last stage of the disease, when their CD4 + T cells drop below 200 cells/cubic millimeter (mm³)⁵. A healthy adult usually has a CD4 + T cell count of 600-1,500 cells/cubic millimeter (mm³). In addition, there are 26 possible conditions identified by the CDC that are criteria for an AIDS diagnosis⁵. Most of the conditions are opportunistic infections that are rarely harmful in healthy individuals. These infections are frequently critical and sometimes fatal because the immune system is unable to protect the body from microbes such as bacteria, viruses, fungi, and parasites. A person with AIDS can experience severe weight loss, diarrhea, neurological conditions, lymphomas,

Kaposi's sarcoma, and other cancers⁵. The debilitating symptoms of AIDS may prevent a person from performing daily activities or maintaining employment.

In the United States, hepatitis C virus (HCV) is a common cause of chronic liver damage and develops more rapidly in people with HIV⁶. HCV can alter the course and treatment of HIV infection⁶. HCV is transmitted by exposure to contaminated blood. HCV is common among persons with hemophilia who were treated with clotting factor concentrates prior to 1987, before concentrates were treated effectively.

It is less common to acquire HCV perinatally or sexually than HIV⁶. People who acquire HIV sexually are no more likely to develop co-infection with HIV and HCV than similarly aged adults in a given population (3-5%)⁶. HCV can be an opportunistic infection, but not an AIDS-defining illness.

Prevention of co-infection with HCV includes stopping injection drug use and not sharing personal items

such as toothbrushes and razors that might be contaminated with blood.

Tuberculosis is an infectious disease that is transmitted through the air⁷. People living with HIV are very susceptible to tuberculosis. TB is the number one cause of death in the world for people infected with HIV.

Of the 10-15 million people in the United States infected with TB bacteria, 10% will develop the TB disease⁷. HIV severely damages the immune system. Therefore, the risk of developing TB disease for a person with HIV/AIDS and TB bacteria is 100 times greater than a person without HIV. People living with HIV/AIDS represent 10-15 percent of all TB cases. It is important for a person with HIV to get tested for TB and to seek treatment if infected to prevent TB disease.

How is HIV/AIDS treated?

During the beginning of the AIDS epidemic, HIV-infected persons were unlikely to live more than one or two years after developing AIDS⁸. Since

that time, medications have been developed to help people with AIDS live longer and healthier. Antiretroviral drugs inhibit HIV by destroying enzymes that allow the virus to reproduce. There are two main types of antiretroviral drugs: reverse transcriptase inhibitors and protease inhibitors.

There is no cure for HIV infection⁸. There are drugs that have been approved to treat HIV infection. These drugs are not used separately but in combination called HAART, highly active antiretroviral therapy⁸. These medications slow the progression of the virus. Patients are on a complicated regimen of multiple medications. Many of the regimens are getting simpler, e.g., multiple drugs in one pill. Drugs that fight HIV are used in combination and adherence to the medical regimen is critical for patients. Strict compliance to the drug treatment is recommended to avoid drug resistance. Not all persons benefit from the drugs, and some may have serious side effects. For some, the combination course of therapy may include other drugs to prevent or treat other infections that can occur in persons with HIV.

HIV/AIDS among minorities in Georgia

In the early 1980s, the HIV/AIDS epidemic in the United States occurred primarily in white men who have sex with men (MSM). The HIV/AIDS epidemic has shifted to include minority communities throughout the United States. Minorities or communities of color include Blacks/African-Americans, Hispanics/Latinos, Asians/Pacific Islanders, and American Indians/Alaska Natives. The HIV/AIDS epidemic in Georgia has shifted from predominantly affecting white men who have sex with men to minority communities, particularly African-Americans, with increasing proportions of women, people who acquire HIV through heterosexual contact, and people living outside of the metropolitan Atlanta area.

Minorities are disproportionately affected by HIV/AIDS in Georgia. The rate of newly reported AIDS cases in Georgia in 2000 for whites was 4 per 100,000, 40 per 100,000 for African-Americans, 8 per 100,000 for Hispanics/Latinos, 2 per 100,000 for Asians/Pacific Islanders, and 9 per 100,000 for American Indians/Alaska Natives. African-Americans were 29% of the population in Georgia but 77% of the AIDS cases reported in 2001. From 1996 to 2000, AIDS was the leading cause of death for African-Americans 25-44 years old in Georgia.

Georgia had an estimated population of 8,383,915 in 2001⁹. In Georgia, whites represent 65% of the population, African-Americans 29%, American Indians/Alaska Natives

0.3%, Asians/Pacific Islanders 2.2%, and 3.8% “Other Race” or “Two or more races”⁹. Persons of Hispanic ethnicity represent 5.3% of the state’s population. Although tenth in population in the United States, Georgia was eighth highest in the total number of AIDS cases reported and seventh highest in the number of people living with AIDS as of December 2000¹⁰. As of December 2001, 24,406 AIDS cases have been reported in the State of Georgia (Table 1).

There are 11,395 people living with AIDS in Georgia and 12,948 have died from AIDS as of December 2001. Of the 11,395 people reported to be living with AIDS in Georgia, 3,288 (29%) are white, 7,752 (68%) are African-American, 312 (3%) are Hispanic/Latino, 25 (<1%) are Asian/Pacific Islander, 10 (<1%) are American Indian/Alaska Native, and 8 (<1%) are of unknown race/ethnicity. The State of Georgia has an AIDS Surveillance system, however it is currently without HIV surveillance. Not including people living with AIDS, the Centers for Disease Control and Prevention (CDC) estimates that 8,200 to 15,300 adults and adolescents know they are infected with HIV in Georgia.

The purpose of this report is to give an overview of the HIV/AIDS epidemic in minority populations in Georgia by analyzing surveillance databases, presenting HIV prevention activities, and evaluating HIV/AIDS treatment and care. This report will summarize HIV/AIDS issues and concerns in Georgia and offer policy recommendations.



AIDS Surveillance

The AIDS Surveillance Unit in the Georgia Division of Public Health's Epidemiology Branch collects AIDS case reports submitted by public and private health care providers in Georgia. The AIDS Surveillance database, as with many surveillance databases, does not represent all cases in Georgia. Moreover, AIDS cases reported to the AIDS Surveillance Unit are more likely to be from publicly-run health care facilities than the private sector. It should be noted that people diagnosed with AIDS may have been infected with HIV for many years. There is currently not an HIV surveillance system in Georgia. Therefore the HIV/AIDS epidemic is not completely understood because AIDS data represent the last stage of HIV. AIDS Surveillance data presented in this report include data entered as of January 23, 2002 for the time period 1981 – December 2001. The number of cases for this time period may change over time because of late reporting and updates, however, the analysis of trends should not change significantly.

Minorities

The proportion of AIDS cases among minorities has increased dramatically from 32% in 1985 to 82% in 2001. Of the 20,167 cumulative AIDS cases reported among males, 61% were minorities (59% African-American and 2% Hispanic/Latino) and 39% were white. Among males, Asians/Pacific Islanders and American Indians/Alaska Natives represent less than 1% of the cases. Among females, 86% of the 4,226 AIDS cases reported were minorities (84% African-American and 2% Hispanic/Latino) and 14% were white. Asians/Pacific Islanders and American Indians/Alaska Natives were less than 1% of the cases among females (Charts 1 – 3).

CHART 1. Percent of AIDS Cases in Georgia, 1985 – 2001

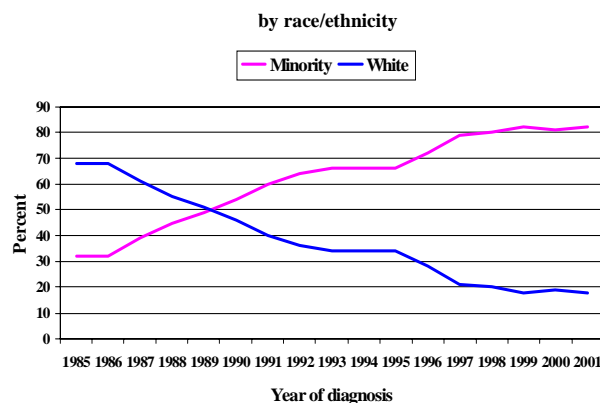
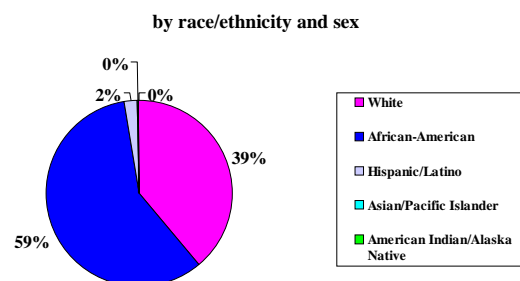
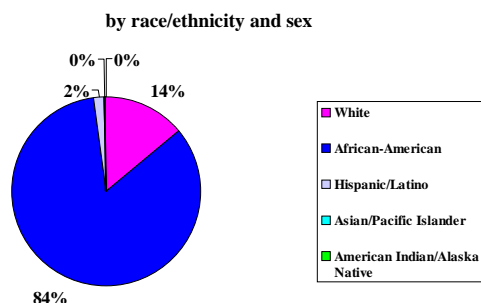


CHART 2. Male AIDS Cases in Georgia, 1981 – 2001



N = 20,167 male cases reported from 1981 - 2001

CHART 3. Female AIDS Cases in Georgia, 1981 – 2001



N = 4,226 female cases reported from 1981 - 2001

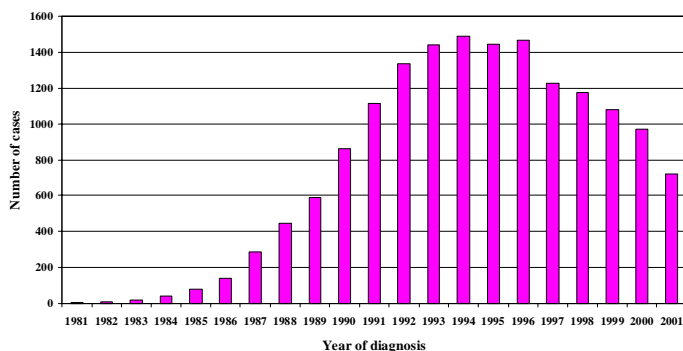


Of the 24,406 cumulative AIDS cases that were reported from 1981 to December 2001 in Georgia, 15,930 (65%) were minorities. The number of newly reported AIDS cases has decreased each year since the mid-1990s (Chart 4). This trend for AIDS is consistent with national data. This is a result of antiretroviral medications delaying the progression of people living with HIV to AIDS.

As of December 2001, there are 8,099 minorities living with AIDS in Georgia. The number of people living with AIDS is increasing each year (Chart 5). The number of deaths has been decreasing in recent years, primarily because persons with AIDS are living longer as a result of effective medications (Chart 6).

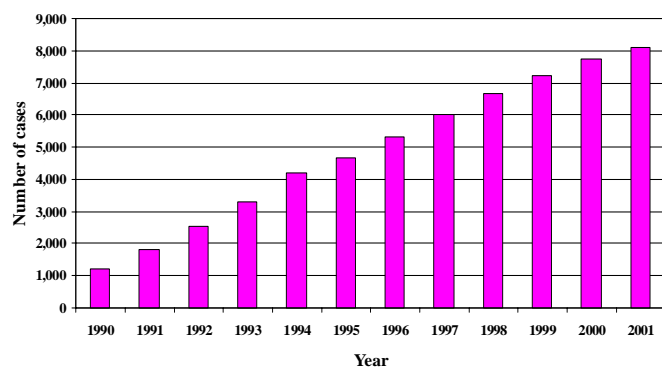
People 30 – 39 years old comprised 45% of the cumulative minority AIDS cases and minorities at least 40 years old have represented the highest proportion of cases since 1999 (Charts 7 – 8).

CHART 4. Minority AIDS Cases in Georgia, 1981 - 2001



N = 15,930 minority cases reported from 1981 - 2001

CHART 5. Minorities Living with AIDS in Georgia, 1990 - 2001



N = 8,099 minorities living with AIDS as of December 2001

CHART 6. Minority Deaths by Year of Death, 1990 - 2001

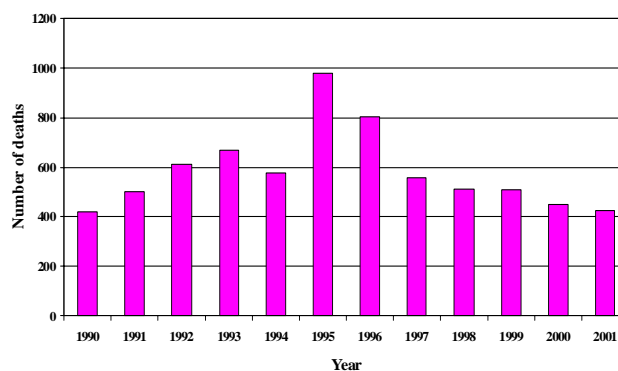
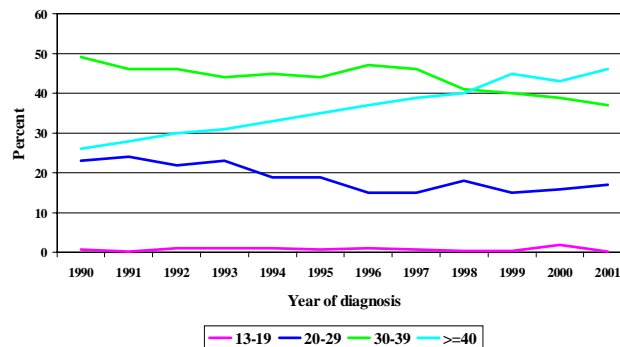


CHART 7. Minority AIDS Cases in Georgia, 1981 – 2001 by age group and race/ethnicity

Age group	African-American	Hispanic/Latino	Asian/Pacific Islander	American Indian/Alaska Native	Total
<13	162	4	1	0	167 (1%)
13 – 19	116	3	0	0	119 (1%)
20 – 29	2,989	124	10	3	3,126 (20%)
30 – 39	6,846	222	20	5	7,093 (45%)
40 – 49	3,841	108	9	4	3,962 (25%)
>=50	1,421	33	6	3	1,463 (9%)
Total	15,375 (97%)	494 (3%)	46 (<1%)	15 (<1%)	15,930 (100%)

CHART 8. Minority AIDS Cases in Georgia, 1990 – 2001 by age group at diagnosis



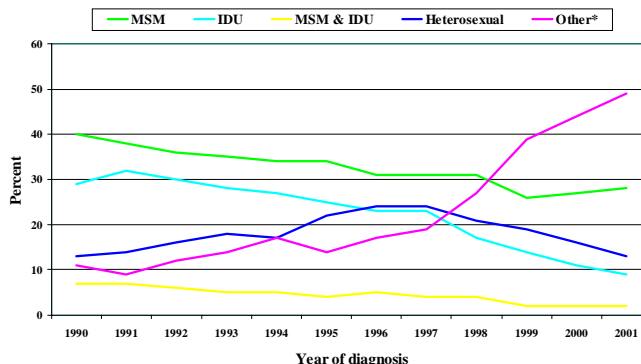


Men who have sex with men (MSM) and people who acquired HIV through heterosexual contact represented 52% of the cumulative minority AIDS cases in Georgia (Chart 9). In 2001, the most common modes of HIV exposure for minorities were men who have sex with men (MSM) and heterosexual contact (Chart 10). The “No Identified Risk” category has increased each year in Georgia and nationally. This is a result of patients or HIV providers not reporting the patient’s mode of HIV exposure. Therefore analyzing risk behaviors among people with HIV and AIDS has becoming increasingly difficult.

CHART 9. Minority AIDS Cases in Georgia, 1981 – 2001
by mode of HIV transmission and race/ethnicity

Mode	African-American	Hispanic	Asian/PI	American Indian/AN	Total
MSM	5,217	199	16	3	5,435 (34%)
IDU	3,702	87	3	5	3,797 (24%)
MSM & IDU	745	27	2	1	775 (5%)
Heterosexual	2,701	79	5	1	2,786 (18%)
NIR	2,619	91	19	4	2,733 (17%)
Transfusion/Hemophilia	229	7	0	1	237 (1%)
Pediatrics	162	4	1	0	167 (1%)
Total	15,375 (97%)	494 (3%)	46 (<1%)	15 (<1%)	15,930 (100%)

CHART 10. Minority AIDS Cases in Georgia, 1990 – 2001
by mode of HIV transmission and year of diagnosis



*Other includes primarily “no identified risk” category



African-Americans accounted for 97% of the cumulative minority AIDS cases, followed by Hispanics (3%), Asians/PI (<1%), and American Indians/AN (<1%). Although the proportions of AIDS cases are smaller for Hispanics, Asians/PI, and American Indians/AN, the numbers of AIDS cases increased from 2000 to 2001 for Hispanics and Asians/Pacific Islanders (Charts 11-13). Among African-Americans in Georgia, 49% of those who have been diagnosed with AIDS have died; Hispanics 36%, Asians/PI 46%, and American Indians/AN 33% (Chart 14).

CHART 11. Minority AIDS Cases in Georgia, 1981 – 2001
by race/ethnicity and sex

Race/ Ethnicity	Males	Females	Total
African-American	11,831	3,544	15,375 (97%)
Hispanic	428	66	494 (3%)
Asian/PI	36	10	46 (<1%)
American Indian/ AN	13	2	15 (<1%)
Total	12,308 (77%)	3,622 (23%)	15,930 (100%)

CHART 12. Minority AIDS Cases in Georgia, 1987 – 2001
by race/ethnicity and year of diagnosis

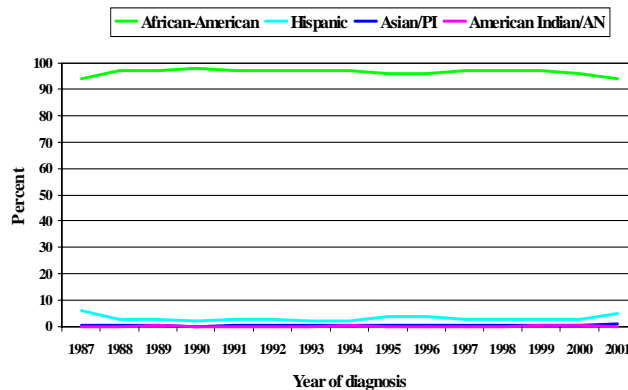


CHART 13. AIDS Cases in Georgia, 1996 – 2001
by race/ethnicity and year of diagnosis

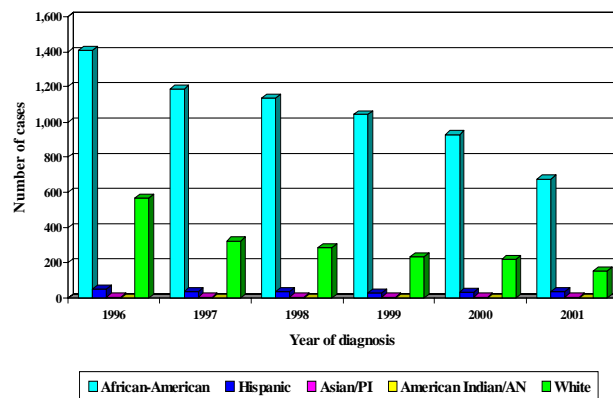
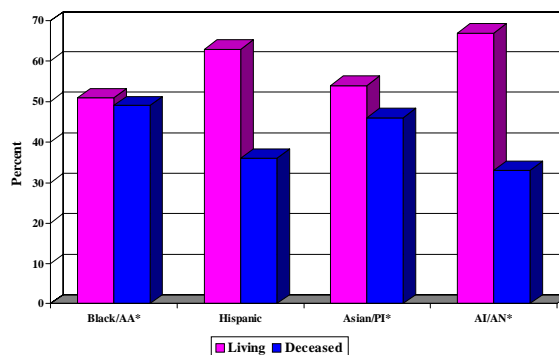


CHART 14. Minority AIDS Cases in Georgia, 1981- 2001
by living status as of 12/01 and race/ethnicity



AA*-African-American PI*-Pacific Islander AI/AN*-American Indian/Alaska Native



Minority men who have sex with men (MSM)/AIDS Surveillance

During the early phase of the epidemic white men accounted for the majority of AIDS cases among men who have sex with men (MSM). In contrast during more recent years, African-American men have accounted for the majority of MSM cases (Chart 15).

Of the 11,592 cumulative MSM AIDS cases reported from 1981 to December 2001, 5,435 (47%) were minorities. As of December 2001, there are 2,690 minority MSM living with AIDS in Georgia, and the number of AIDS deaths has decreased each year since 1995 (Charts 16 – 18).

CHART 15. Percent of MSM AIDS Cases in Georgia, 1985 – 2001 by race/ethnicity

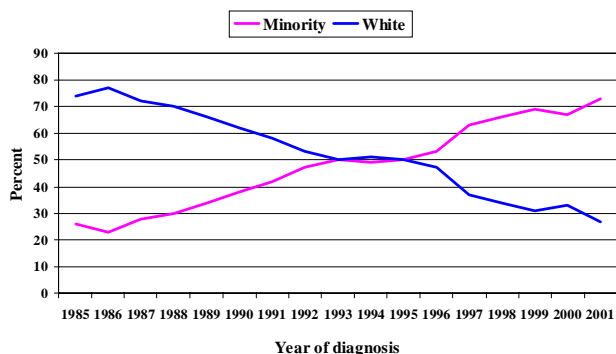
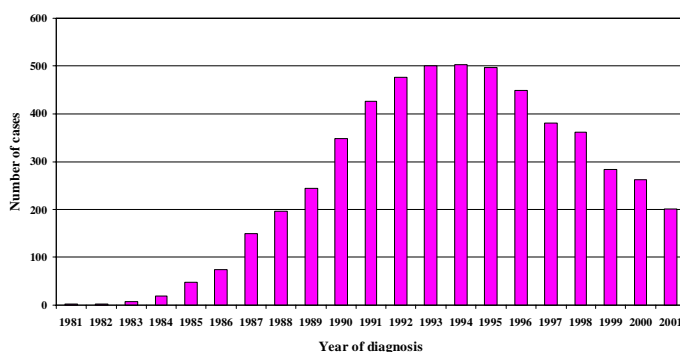
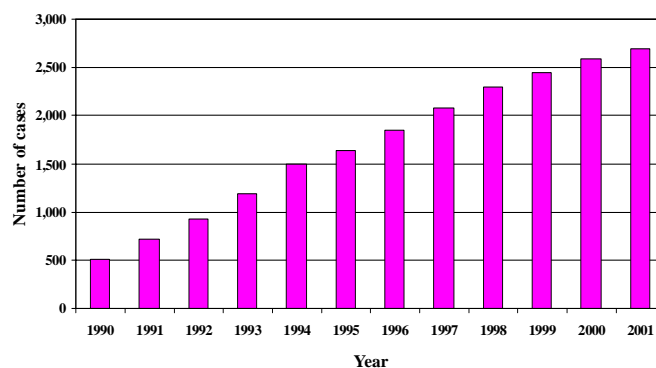


CHART 16. Minority MSM AIDS Cases in Georgia, 1981 - 2001



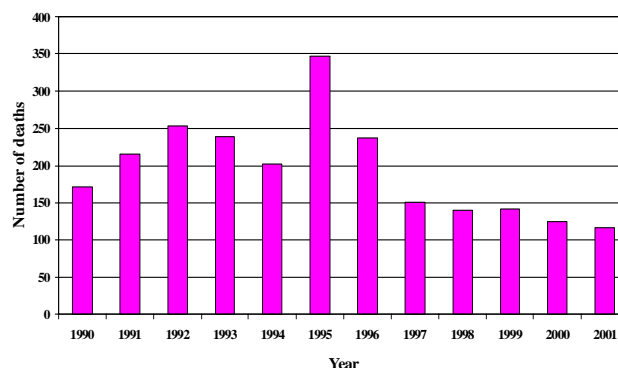
N = 5,435 minority MSM cases reported 1981 - 2001

CHART 17. Minority MSM Living with AIDS in Georgia, 1990 - 2001



N = 2,690 minority MSM living with AIDS as of December 2001

CHART 18. Minority MSM Deaths by Year of Death, 1990 - 2001





Persons under 40 years old comprised a large percentage (76%) of the cumulative minority MSM AIDS cases in Georgia. Each year, the 30 – 39 age group has accounted for the largest proportion of AIDS cases each year for minority MSM (Charts 19 - 20).

Of the cumulative minority MSM cases, African-Americans were most of the cases (96%), followed by Hispanics (4%), Asians/PI (<1%), and American Indians/AN (<1%) (Chart 21). For each race/ethnicity, the proportion of cases each year is shown in Chart 22.

Among African-American, Hispanic, Asian/PI, and American Indian/AN MSM diagnosed with AIDS, the proportion who have died was 51%, 44%, 37%, and 33% respectively (Chart 23).

CHART 19. Minority MSM AIDS Cases in Georgia, 1981 – 2001
by age group and race/ethnicity

Age group	African-American	Hispanic/Latino	Asian/Pacific Islander	American Indian/Alaska Native	Total
13 – 19	34	3	0	0	37 (<1%)
20 – 29	1,413	51	1	1	1,466 (27%)
30 – 39	2,496	98	8	1	2,603 (48%)
40 – 49	962	43	6	1	1,012 (19%)
≥50	312	4	1	0	317 (6%)
Total	5,217 (96%)	199 (4%)	16 (<1%)	3 (<1%)	5,435 (100%)

CHART 20. Minority MSM AIDS Cases in Georgia, 1990– 2001
by age group at diagnosis

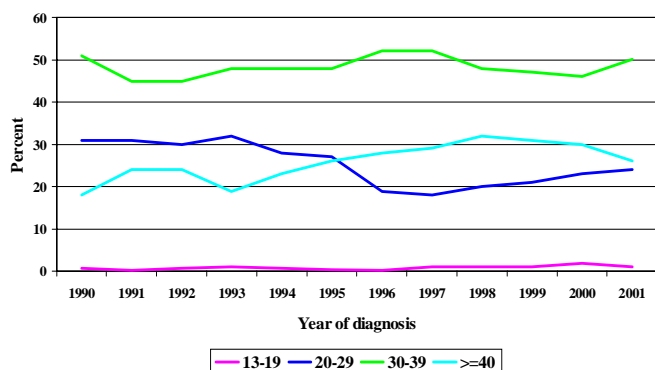


CHART 21. Minority MSM AIDS Cases in Georgia, 1981 – 2001
by race/ethnicity and sex

Race/ethnicity	Cases	Percent
African-American	5,217	96%
Hispanic	199	4%
Asian/PI	16	<1%
American Indian/AN	3	<1%
Total	5,435	100%

CHART 22. Minority MSM AIDS Cases in Georgia, 1987 – 2001
by race/ethnicity and year of diagnosis

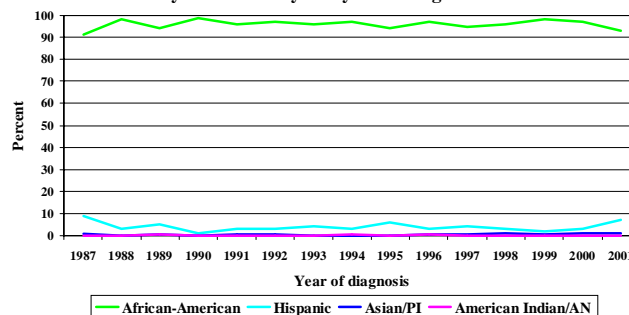
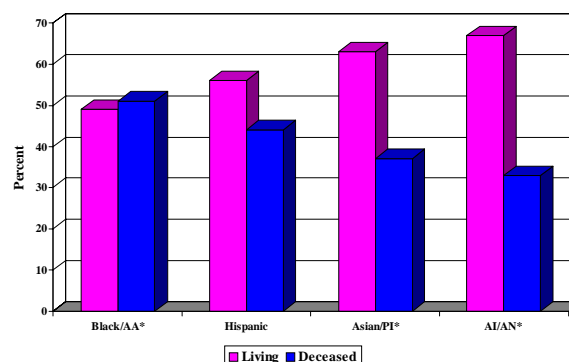


CHART 23. Minority MSM AIDS Cases in Georgia, 1981- 2001
by living status as of 12/01 and race/ethnicity



AA*-African-American PI*-Pacific Islander AI/AN*-American Indian/Alaska Native



Minority females/AIDS Surveillance

Minority females, mainly African-American females, have represented the majority of female AIDS cases in Georgia since the beginning of the epidemic. Minority females comprised the majority of AIDS cases among females in 1985 (64%) increasing to 88% in 2001. Of the 4,266 cumulative female AIDS cases reported from 1981 to December 2001 in Georgia, 3,622 (85%) were minorities. As of December 2001, there are 1,999 minority females living with AIDS in Georgia, and the number of deaths has decreased each year since 1995 (Charts 24 – 27).

CHART 24. Percent of Female AIDS Cases in Georgia, 1985 – 2001 by race/ethnicity

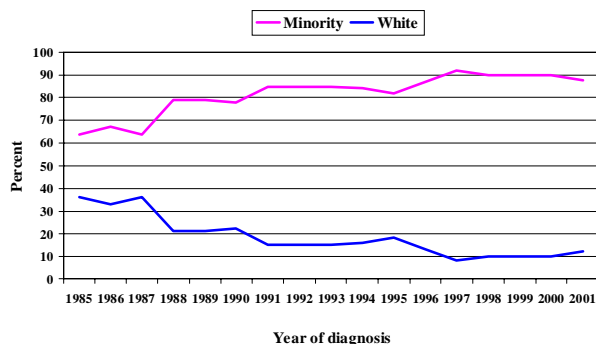
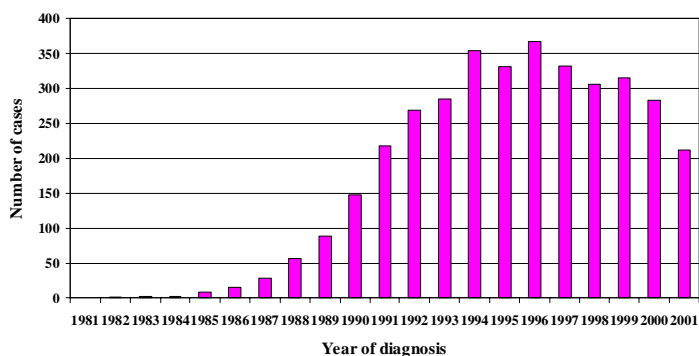
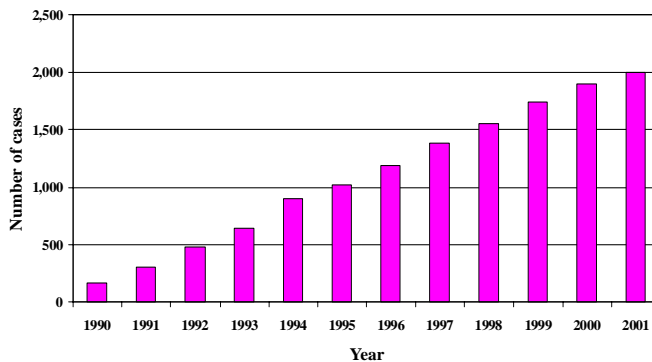


CHART 25. Minority Female AIDS Cases in Georgia, 1981 - 2001



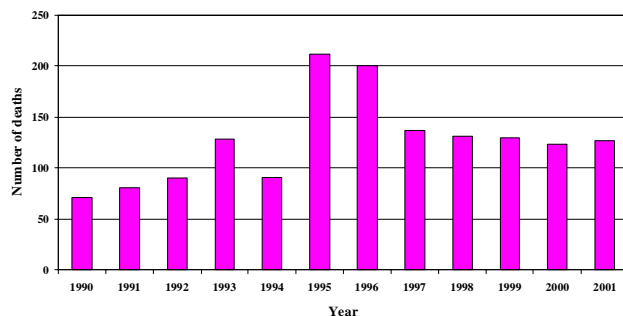
N = 3,622 cases reported from 1981 - 2001

CHART 26. Minority Females Living with AIDS in Georgia, 1990 - 2001



N = 1,999 minority females living with AIDS as of December 2001

CHART 27. Minority Female Deaths by Year of Death, 1990 - 2001



Although the 30 – 39 age group represented 42% of cumulative AIDS cases among minority females, persons at least 40 years old had the highest number of AIDS cases in 2001 (Charts 28 -29). The most frequently reported mode of HIV transmission for cumulative AIDS cases among minority females was heterosexual contact (43%) (Chart 30). Cumulative minority female AIDS cases by mode of HIV transmission and race/ethnicity are shown in Chart 31.

Of the cumulative minority female AIDS cases in Georgia, African-Americans were most of the cases (98%), followed by Hispanics (2%), Asians/PI (<1%), and American Indians/AN (<1%) (Chart 32).

CHART 28. Minority Female AIDS Cases in Georgia, 1981 – 2001
by age group and race/ethnicity

Age group	African-American	Hispanic/Latino	Asian/Pacific Islander	American Indian/Alaska Native	Total
<13	90	0	1	0	91 (2%)
13 – 19	59	0	0	0	59 (2%)
20 – 29	762	17	3	0	782 (22%)
30 – 39	1,486	27	4	0	1,517 (42%)
40 – 49	779	18	1	1	799 (22%)
≥50	368	4	1	1	374 (10%)
Total	3,544 (98%)	66 (2%)	10 (<1%)	2 (<1%)	3,622 (100%)

CHART 29. Minority Female AIDS Cases in Georgia, 1990 – 2001
by age group at diagnosis

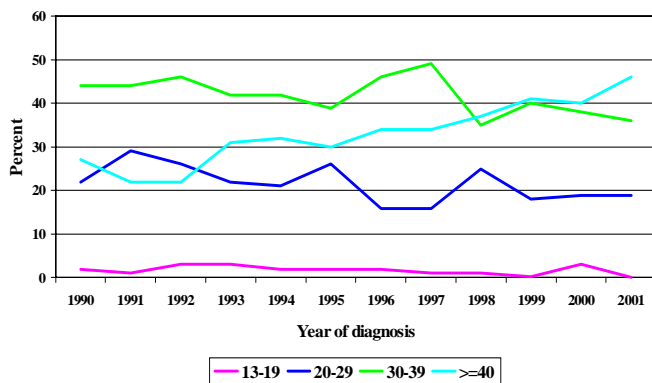


CHART 30. Minority Female AIDS Cases in Georgia, 1981 – 2001
by mode of HIV transmission

Mode	Cases	Percent
IDU	962	27%
Heterosexual	1,558	43%
NIR	894	25%
Transfusion/Hemophilia	117	3%
Pediatrics	91	3%
Total	3,622	100%

CHART 31. Minority Female AIDS Cases in Georgia, 1981 – 2001
by mode of HIV transmission and race/ethnicity

Mode	African-American	Hispanic	Asian/PI	American Indian/AN	Total
IDU	941	19	1	1	962 (27%)
Heterosexual	1,520	34	4	0	1,558 (43%)
NIR	881	9	4	0	894 (25%)
Transfusion/Hemophilia	112	4	0	1	117 (3%)
Pediatrics	90	0	1	0	91 (3%)
Total	3,544 (98%)	66 (2%)	10 (0.3%)	2 (0.1%)	3,622 (100%)

CHART 32. Minority Female AIDS Cases in Georgia, 1981 – 2001
by race/ethnicity and sex

Race/ethnicity	Cases	Total
African-American	3,544	98%
Hispanic	66	2%
Asian/PI	10	<1%
American Indian/AN	2	<1%
Total	3,622	100%



For each race/ethnicity, the proportion of cases each year is shown in [Chart 33](#). Among African-American, Hispanic, Asian/PI, and American/AN females with AIDS, the proportion who have died was 45%, 32%, 70%, and 50% respectively ([Chart 34](#)).

CHART 33. Minority Female AIDS Cases in Georgia, 1987 – 2001

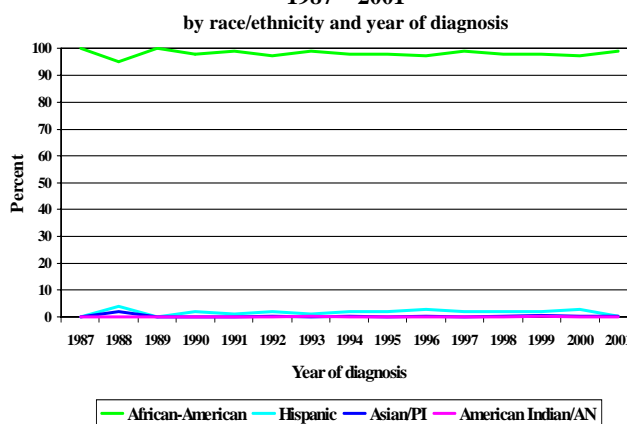
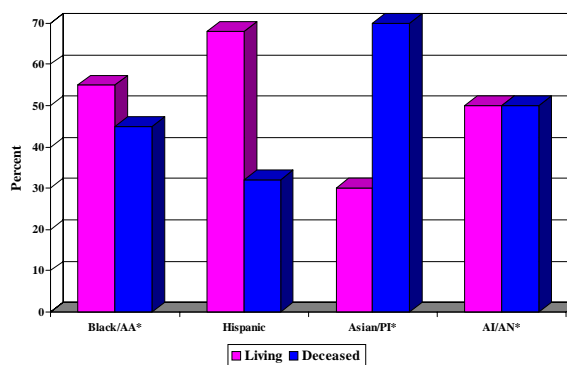


CHART 34. Minority Female AIDS Cases in Georgia, 1981- 2001

by living status as of 12/01 and race/ethnicity



AA*-African-American PI*-Pacific Islander AI/AN*-American Indian/Alaska Native

Minority injection drug users (IDU)/AIDS Surveillance

Since the 1980s, minorities have represented the majority of AIDS cases among injection drug users. Of the 4,311 cumulative IDU AIDS cases reported from 1981 to December 2001 in Georgia, 3,797 (88%) were minorities (Charts 35 – 36). As of December 2001, there are 1,671 minority injection drug users living with AIDS in Georgia (Chart 37), and the number of AIDS deaths has decreased since 1995 (Chart 38). Persons 30 - 39 years old were 47% of cumulative AIDS cases for minority IDU (Chart 39).

CHART 35. Percent of IDU AIDS Cases in Georgia, 1985 – 2001 by race/ethnicity

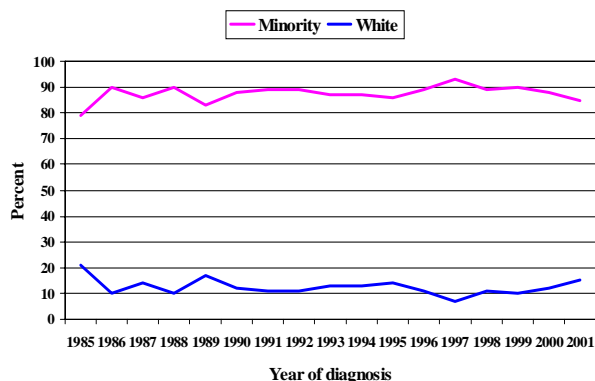
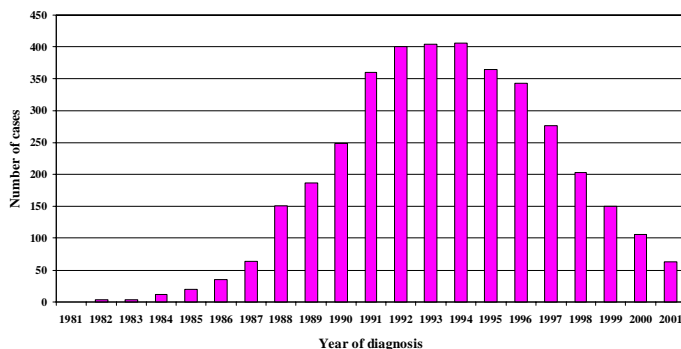
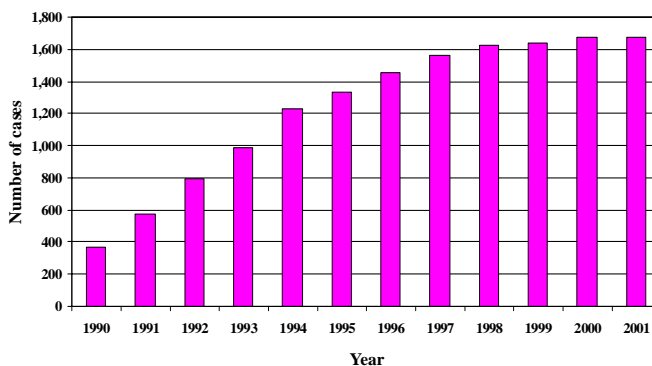


CHART 36. Minority IDU AIDS Cases in Georgia, 1981 - 2001



N = 3,797 cases reported from 1981 - 2001

CHART 37. Minority IDU Living with AIDS in Georgia, 1990 - 2001



N = 1,671 minority IDU living with AIDS as of December 2001

CHART 38. Minority IDU Deaths by Year of Death, 1990 - 2001

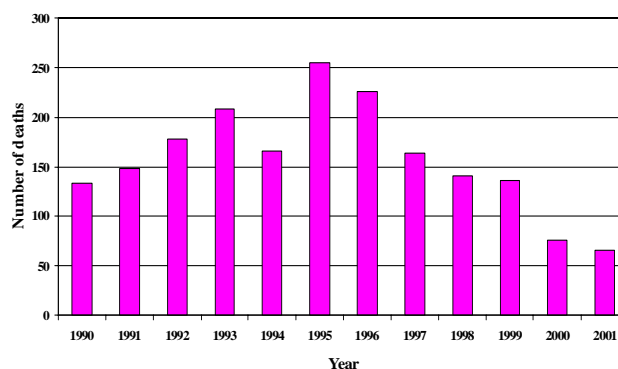


CHART 39. Minority IDU AIDS Cases in Georgia, 1981 – 2001 by age group and race/ethnicity

Age group	African-American	Hispanic/Latino	Asian/Pacific Islander	American Indian/Alaska Native	Total
13 – 19	6	0	0	0	6 (<1%)
20 – 29	368	13	0	1	382 (10%)
30 – 39	1,754	41	2	2	1,799 (47%)
40 – 49	1,313	27	1	2	1,343 (35%)
≥50	261	6	0	0	267 (7%)
Total	3,702 (97%)	87 (2%)	3 (<1%)	5 (<1%)	3,797 (100%)



The percentage of people 40 years old and older has increased significantly among minority IDU diagnosed with AIDS in Georgia. Persons at least 40 years old accounted for 84% of the AIDS cases among minority IDU in Georgia in 2001 (Chart 40).

African-Americans were the majority of the cumulative minority IDU cases (97%), followed by Hispanics/Latinos (2%), Asians/PI (<1%), and American Indians/AN (<1%) (Chart 41). For each race/ethnicity, the proportion of cases each year is shown in Chart 42. Among African-American, Hispanic, Asian/PI, and American Indian/AN injection drug users diagnosed with AIDS, the proportion who have died was 56%, 36%, 67%, and 40% respectively (Chart 43).

CHART 40. Minority IDU AIDS Cases in Georgia, 1990 – 2001
by age group at diagnosis

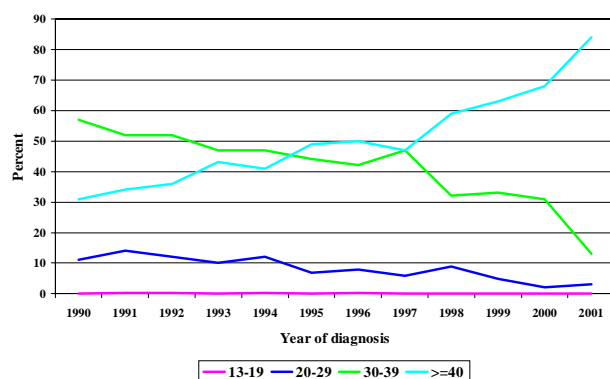


CHART 41. Minority IDU AIDS Cases in Georgia, 1981 – 2001
by race/ethnicity and sex

Race/ethnicity	Cases	Percent
African-American	3,702	97%
Hispanic	87	2%
Asian/PI	3	<1%
American Indian/AN	5	<1%
Total	3,797	100%

CHART 42. Minority IDU AIDS Cases in Georgia, 1987 – 2001
by race/ethnicity and year of diagnosis

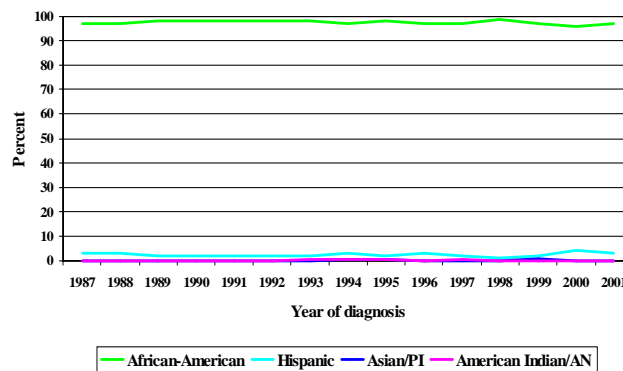
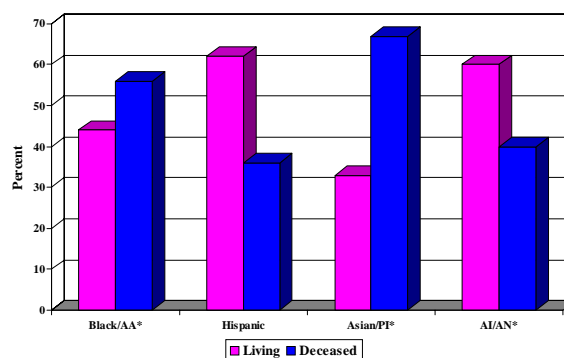


CHART 43. Minority IDU AIDS Cases in Georgia, 1981- 2001
by living status as of 12/01 and race/ethnicity



AA*-African-American PI*-Pacific Islander AI/AN*-American Indian/Alaska Native

Geography/AIDS Surveillance

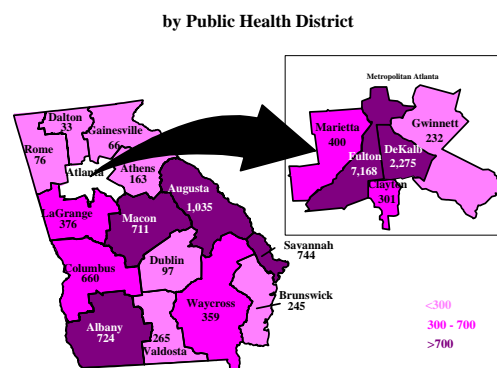
The State of Georgia has 19 public health districts. Each district includes a single county or a grouping of counties. The five metropolitan Atlanta Public Health Districts include eight counties: Fulton, DeKalb, Cobb, Douglas, Gwinnett, Clayton, Rockdale, and Newton.

The highest number of cumulative AIDS cases in Georgia was reported in the Fulton Health District (n=10,910), followed by DeKalb (n=3,456), Augusta (n=1,305), Savannah (n=1,028), and Macon (n=938) (Chart 44). Among minorities reported with AIDS in the five metropolitan Atlanta Public Health Districts, Fulton reported 7,168 cases and DeKalb reported 2,275 as of December 2001. The following districts reported the highest AIDS cases among minorities outside of the five metropolitan Atlanta Public Health Districts: Augusta (n=1,035), Savannah (n=744), and Albany (n=724) (Chart 45).

Among minority men who have sex with men (MSM), Fulton reported 2,670 cases, followed by DeKalb (n=928), Augusta (n=301), Macon (n=232), and Albany (n=219) (Chart 46).

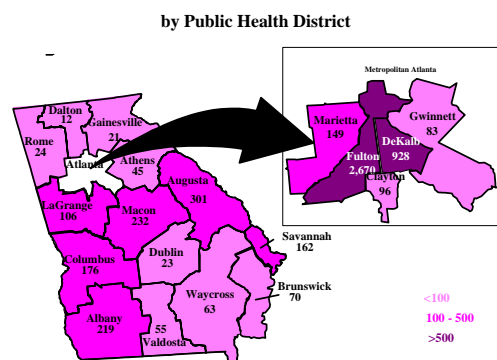
The Fulton Health District reported 1,393 AIDS cases among minority females from 1981-2001, followed by DeKalb (n=426), Augusta (n=252), Albany (n=227), and Columbus (n=210) (Chart 47).

CHART 45. Minority AIDS Cases in Georgia, 1981 - 2001



N = 15,930 minorities reported with AIDS in Georgia, 1981 - 2001

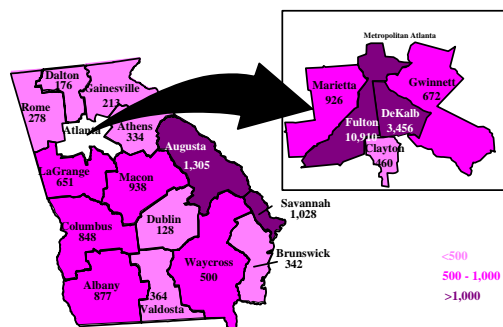
CHART 46. Minority MSM AIDS Cases in Georgia, 1981 - 2001



N = 5,435 minority MSM reported with AIDS in Georgia, 1981 - 2001

CHART 44. AIDS Cases in Georgia, 1981 - 2001

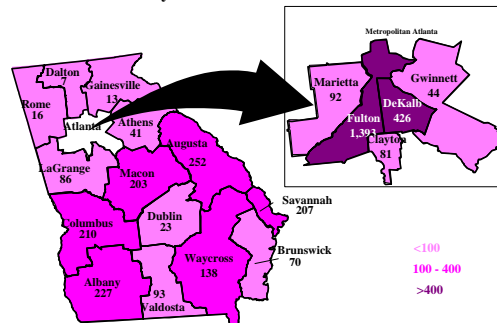
by Public Health District



N = 24,406 reported with AIDS in Georgia, 1981 - 2001

CHART 47. Minority Female AIDS Cases in Georgia, 1981 - 2001

by Public Health District



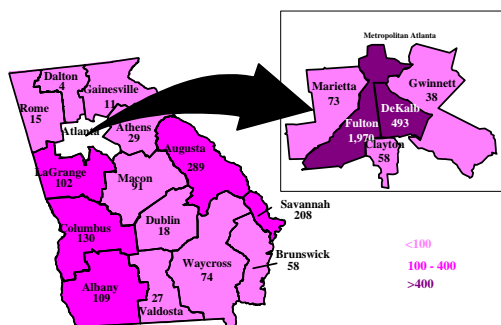
N = 3,622 minority females reported with AIDS in Georgia, 1981 - 2001



The Fulton Health District reported 1,970 AIDS cases among minority IDU from 1981 – 2001, followed by DeKalb (n=493), Augusta (n=289), Savannah (n=208), and Columbus (n=130) (Chart 48).

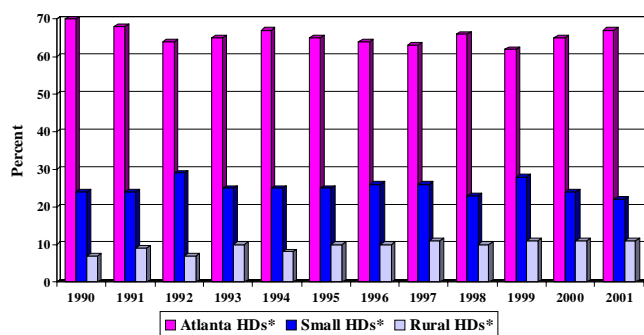
Each year, since 1990, the eight counties that comprise the five metropolitan Atlanta Public Health Districts have accounted for the largest proportion of minority cases. The largest proportion of minority MSM reported with AIDS in Georgia was diagnosed in the five metropolitan Atlanta Public Health Districts from 1990 - 2001. However, the proportion of AIDS cases reported each year among minority females from non-Atlanta Public Health Districts has been significant. In 2001, 41% of AIDS cases in minority females were reported in non-metropolitan Atlanta districts. Among minority injection drug users reported with AIDS in Georgia, the largest proportion was diagnosed in the five metropolitan Atlanta Public Health Districts each year (Charts 49-52).

CHART 48. Minority IDU AIDS Cases in Georgia, 1981 - 2001
by Public Health District



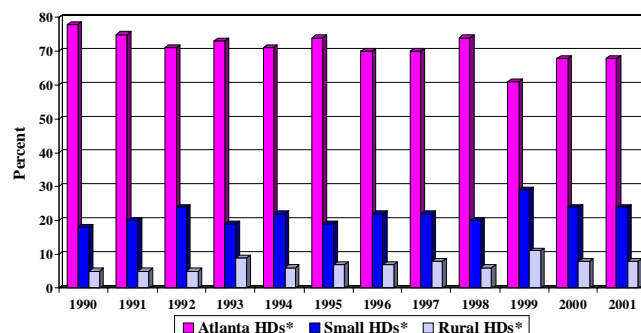
N = 3,797 minority IDU reported with AIDS in Georgia, 1981 - 2001

CHART 49. Minority AIDS Cases in Georgia, 1990 – 2001
by Public Health District (HD) groupings



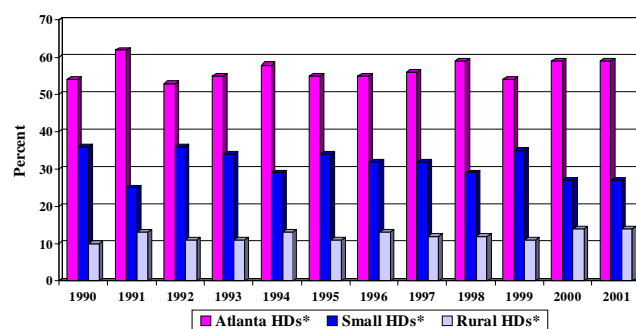
*Note : 8-county metropolitan Atlanta includes the Marietta, Fulton, Clayton, Gwinnett, and DeKalb districts. Districts that include a small metropolitan statistical area (MSA) are Albany, Athens, Augusta, Columbus, Macon, and Savannah and the remaining districts are rural health districts.

CHART 50. Minority MSM AIDS Cases in Georgia, 1990 – 2001
by Public Health District (HD) groupings



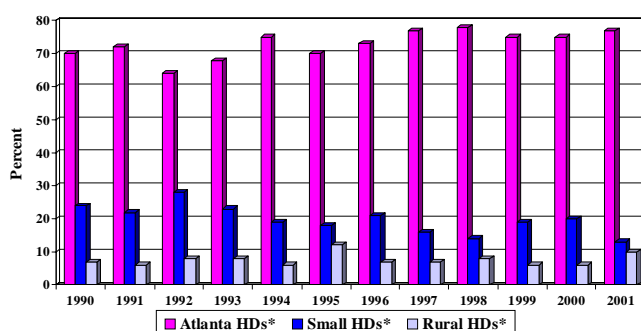
*Note : 8-county metropolitan Atlanta includes the Marietta, Fulton, Clayton, Gwinnett, and DeKalb districts. Districts that include a small metropolitan statistical area (MSA) are Albany, Athens, Augusta, Columbus, Macon, and Savannah and the remaining districts are rural health districts.

CHART 51. Minority Female AIDS Cases in Georgia, 1990 – 2001
by Public Health District (HD) groupings



*Note : 8-county metropolitan Atlanta includes the Marietta, Fulton, Clayton, Gwinnett, and DeKalb districts. Districts that include a small metropolitan statistical area (MSA) are Albany, Athens, Augusta, Columbus, Macon, and Savannah and the remaining districts are rural health districts.

CHART 52. Minority IDU AIDS Cases in Georgia, 1990 – 2001
by Public Health District (HD) groupings



*Note : 8-county metropolitan Atlanta includes the Marietta, Fulton, Clayton, Gwinnett, and DeKalb districts. Districts that include a small metropolitan statistical area (MSA) are Albany, Athens, Augusta, Columbus, Macon, and Savannah and the remaining districts are rural health districts.



**Table 1. Cumulative AIDS Cases Reported in Georgia, 1981 – 2001
by race/ethnicity, mode, and sex**

Race/ethnicity	Living	Deceased	Unknown	Total
White	3,288	5,159	16	8,463(35%)
African-American	7,752	7,580	43	15,375(63%)
Hispanic/Latino	312	179	3	494(2%)
Asian/Pacific Islander	25	21	0	46(<1%)
American Indian/ Alaska Native	10	5	0	15(<1%)
Unknown	8	4	1	13(<1%)
Total	11,395	12,948	63	24,406(100%)
Mode of HIV transmission				
Men who have sex with men (MSM)	4,923	6,642	31	11,596(48%)
Injection drug use(IDU)	1,896	2,408	7	4,311(18%)
MSM & IDU	602	729	0	1,331(5%)
Heterosexual contact	1,755	1,453	5	3,213(13%)
No identified risk(NIR)	1,955	1,314	20	3,289(13%)
Transfusion/Hemophilia	166	290	0	456(2%)
Pediatrics	98	112	0	210(0.9%)
Total	11,395	12,948	63	24,406(100%)
Sex				
Male	9,079	11,044	52	20,175(83%)
Female	2,316	1,904	11	4,231(17%)
Total	11,395	12,948	63	24,406(100%)



HIV Counseling and Testing (HIV C & T)

HIV Counseling and Testing is a program that tests people for HIV in public health and publicly-funded facilities in Georgia such as county health departments, drug treatment centers, community-based organizations, juvenile detention centers, jails, hospitals, student health clinics at universities, and several outreach projects.

The HIV Counseling and Testing System (HIV CTS) data are submitted to the STD/HIV Prevention section in the Georgia Division of Public Health. In addition to the HIV Counseling and Testing System Management (CTSM) Unit managing a state-wide system of nearly 400 public health and publicly-funded testing sites, it is responsible for performing regular audits to assure the quality of HIV testing service provision, documentation, and provides information and technical assistance for the monthly reports of the testing activity and demographics, that are required from all public health and publicly-funded HIV counseling and testing programs.

This type of data is useful in analyzing trends and demographics of people infected with HIV and supporting HIV databases at the CDC. HIV Counseling and Testing data should be analyzed carefully, as an individual data point represents a testing episode and not an individual patient or client. Additionally, we are unable to remove duplicates; as a result every positive test may not represent a single person.

Of the 82,031 tests completed at approximately 400 testing sites in Georgia in 2001, 1,951 or 2.4% tests were positive for HIV. Of the 1,951 positive tests, 1,543 (79%) were tests performed on African-Americans, 304 (16%) were tests performed on whites, 86 (4%) were tests performed on Hispanics/Latinos, 6 (<1%) were tests performed on

Asians/Pacific Islanders, 3 (<1%) were tests performed on American Indians/Alaska Natives, 8 (<1%) were tests performed on other races/ethnicities, and 1 (<1%) was performed on a person who had an undetermined race/ethnicity. The positivity rate in 2001 was 1.2% for whites, 3.1% for African-Americans, 1.5% for Hispanics, 0.9% for Asians/Pacific Islanders, and 3.5% for American Indians/Alaska Natives ([Table 2](#)).

Among African-Americans, the top five health districts for HIV positivity rates at HIV Counseling and Testing sites in 2001 were DeKalb (5.5%), Fulton (4.1%), Columbus (4.1%), Dalton (2.8%), and Savannah (2.6%) ([Table 3](#)).

Among Hispanics, the top five health districts for HIV positivity rates at HIV Counseling and Testing sites in 2001 were DeKalb (8.6%), Valdosta (4.1%), Clayton (3.8%), Albany (3.2%), and Rome (2.8%) ([Table 3](#)).

The number of HIV tests performed has remained stable from 1997 to 2001. In 1997, 80,934 tests were completed for HIV at HIV C & T sites, while 82,031 tests for HIV were completed in 2001 ([Chart 53](#)). The positivity rates have ranged from 2.2% – 2.5% from 1997 to 2001 ([Chart 54](#)). The total positivity rate in 2001 was 2.4%. The positivity rate for tests taken by African-American males in 2001 was 4.7% and represents the highest proportion of cases from 1997 – 2001 ([Charts 55-56](#)).

HIV Positive Tests by exposure category and sex in 2001 are shown in [Charts 57](#) and [58](#). Among tests taken by minority men that were positive, MSM and heterosexual contact represented 81% of exposure category. Heterosexual contact was the mode of exposure for 83% of tests taken by minority females.



Table 2. Summary of Positive Test Results, by Race and Sex, 2001

	Race/ethnicity							
	White	African-American	Hispanic	Asian/PI	American Indian/AN	Other	Undetermined	Total
Male Tests	11,135	21,698	2,150	274	37	111	24	35,429
Male Positives	230	1,025	67	2	2	7	1	1,334
Male Positivity Rate (%)	2.1%	4.7%	3.1%	0.7%	5.4%	6.3%	4.2%	3.8%
Female Tests	13,428	28,847	3,561	398	48	283	27	46,592
Female Positives	74	517	19	4	1	1	0	616
Female Positivity Rate (%)	0.6%	1.8%	0.5%	1%	2.1%	0.4%	0%	1.3%
Not Specified Tests	1	3	1	0	1	0	4	10
Not Specified Positives	0	1	0	0	0	0	0	1
Total Tests	24,564	50,548	5,712	672	86	394	55	82,031
Total Positives	304	1,543	86	6	3	8	1	1,951
Total Positivity Rate (%)	1.2%	3.1%	1.5%	0.9%	3.5%	2.0%	1.8%	2.4%



**Table 3. Georgia Year 2001 HIV Counseling and Testing Seroprevalence Rates
by Health District Ranked Highest to Lowest for Total Positivity**

Rank	District	Total Tests	Total Positivity Rate	White	African- American	Hispanic	Other
1	DeKalb	7,247	5.7%	6.8%	5.5%	8.6%	1.1%
2	Fulton	21,052	3.9%	3.8%	4.1%	1.8%	2.2%
3	Columbus	3,169	3.2%	1.6%	4.1%	-	3.2%
4	Savannah	5,540	2.6%	2.7%	2.6%	1.5%	1.1%
5	Clayton	1,425	1.9%	0.8%	2.2%	3.8%	1.6%
6	Lawrenceville	1,697	1.5%	0.9%	2.3%	2.2%	1.5%
7	Marietta	2,793	1.4%	0.6%	2.3%	1.6%	-
8	Albany	4,202	1.3%	0.1%	1.7%	3.2%	-
9	Lagrange	3,607	1.3%	0.9%	1.9%	0.6%	-
10	Dalton	2,117	1.3%	1.7%	2.8%	0.4%	-
11	Augusta	4,492	1.1%	0.5%	1.4%	1.2%	1.8%
12	Rome	1,992	1.1%	0.6%	2.1%	2.8%	-
13	Dublin	1,215	1.1%	-	1.7%	-	-
14	Waycross	5,083	1.0%	0.4%	1.8%	0.5%	-
15	Valdosta	2,883	1.0%	0.4%	1.2%	4.1%	-
16	Macon	6,164	0.8%	0.3%	1.1%	-	-
17	Athens	2,854	0.7%	0.3%	1.3%	-	-
18	Gainesville	1,813	0.7%	0.3%	2.5%	-	5.6%
19	Brunswick	2,686	0.6%	0.4%	0.8%	-	-
Total	Georgia	82,031	2.4%	1.2%	3.1%	1.5%	1.5%



Chart 53. HIV Tests Provided and Positives Identified, 1997-2001

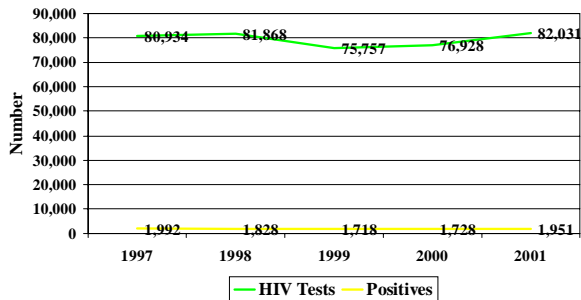


Chart 56. HIV Positivity by Race and Sex, 1997-2001

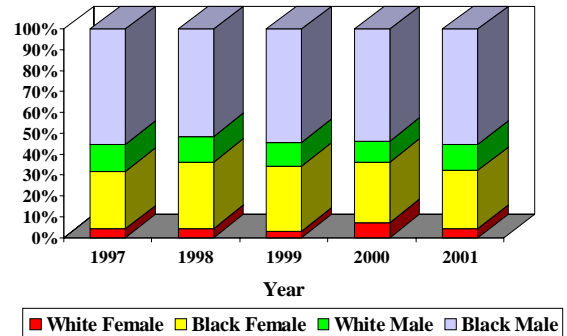


Chart 54. HIV Positivity Rates, All Tests, 1997-2001

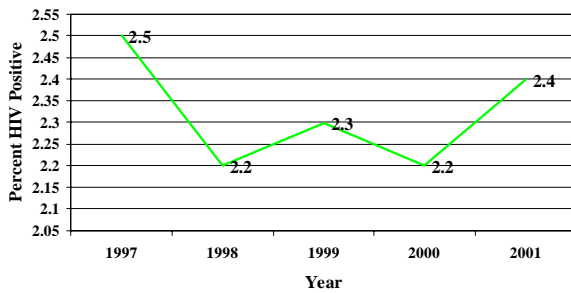
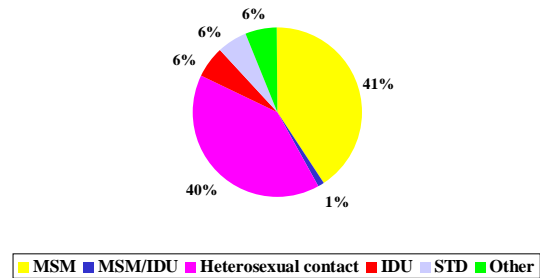


Chart 57. Male Minorities'* HIV Positive Tests by exposure category, Georgia, 2001



*Includes all known minorities (non-Whites) tested for HIV

Chart 55. HIV Positivity by Race and Sex, 2001

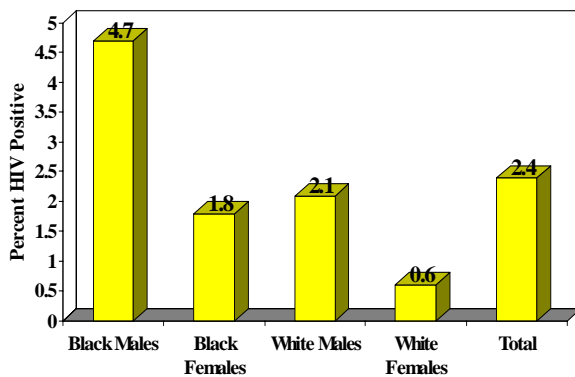
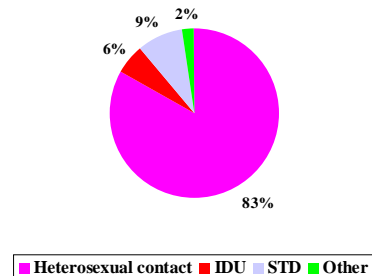


Chart 58. Female Minorities'* HIV Positive Tests by exposure category, Georgia, 2001



*Includes all known minorities (non-Whites) tested for HIV



Supplement to HIV/AIDS Surveillance (SHAS)

The Grady Infectious Disease Program (IDP) is one of the largest and most comprehensive HIV/AIDS care program in the United States. The IDP was established in 1986 at Grady Memorial Hospital in Atlanta, Georgia and in 1993 moved to the 90,000 square foot Ponce de Leon facility. Grady IDP serves approximately 4,000 adult patients and 300 children primarily infected with HIV. It consists of a partnership of agencies including AID Atlanta, Emory University, Centers for Disease Control and Prevention, Georgia Department of Family and Children's Services, and LIVING Room. The services provided at Grady IDP include primary care, dental, mental health, clinical research, pharmacy, and women's, family and other subspecialty clinics. IDP physicians at Grady Memorial Hospital treat HIV and AIDS inpatients within a special immunology ward, and on most other wards or services.

The Supplement to HIV/AIDS Surveillance (SHAS) Project is a CDC-sponsored cross sectional study of individuals with AIDS in the Grady Health System. The SHAS interview focuses on socioeconomics, alcohol and drug use, sexual behavior, history of infectious diseases [including sexually transmitted diseases (STDs)], access to health and social services, HIV testing and therapies; and for women, child health and reproductive/gynecological issues. Providing data for both improving prevention programs and for improving clinical and other services for HIV-infected persons is the mission of the SHAS project.

In November 2000, a revision was introduced to enhance and streamline many portions of the questionnaire. Thus, some trend variables available in the previous report have temporarily become summary analysis variables. Where possible, trend analysis was continued, but a new annual reporting period was introduced to maximize interpretation of available data that was affected by the gap between the prior version and revised interviews.

As with all cross-sectional, or "convenience sample" data, representativeness and refusal rates may affect the validity of comparisons made between dissimilar community groups or geographical service areas. With the current analysis, applying the results to groups unlike the population served by the Grady Health System may be unwarranted.

Analysis of persons refusing as compared to persons interviewed showed that persons of white non-Hispanic

(white) race may be under-represented. Other differences found were in certain categories of HIV exposure risk, but these are primarily attributable to the addition of risk information to case registry data for those having no identifiable risk prior to the interview. Further, the refusal rate was low (8% among all cases targeted, and 16% among those medically able to participate); the participation rate among those medically able was 63%. If conclusions or generalizations need to be drawn about white persons, in particular, further investigation may be required.

From November 21, 2000 to November 20, 2001, 260 SHAS interviews were completed, of which 225 were minority participants (87%). Among minorities, most were male (78%), African American (96%), never married (66%), had completed high school (67%), received Social Security benefits (71%), had a household income of less than \$10,000 (52%), were unemployed (77%), had publicly funded (65%) or no health insurance (33%), and were living either alone or with others in a house or apartment (82%) ([Charts 59 - 61](#)). Among minorities, most (65%) reported that their job situation changed when they learned they were infected with HIV: 41% reported that they had to quit or were laid off from work because they were too ill; an additional 11% lost their jobs for some other reason; and, 13% either started or returned to work ([Chart 62](#)).

Since 1991, the proportion that used crack cocaine has been higher among minorities than among whites. For both groups, the trend has been toward increased prevalence of crack use, peaking at 34% for whites and remaining above 50% for minorities in the current period ([Chart 63](#)).

The proportion of minorities injecting drugs was 22% for the current period, which appears consistent with an overall slight downward trend in prevalence. Once in 1995 and since 1997, the proportion injecting drugs among whites has either spiked above or nearly equaled the proportion injecting among minorities; however, the trend appears to be toward a similar proportion injecting drugs overall, if not a reversal, where prevalence may remain slightly higher among whites than minorities ([Chart 64](#)).

[Table 4](#) represents the proportion of STDs and sexual behaviors among minorities interviewed for the 2000-2001 SHAS Project.

[Table 5](#) includes information on HIV testing patterns of minorities interviewed for the 2000-2001 SHAS Project.

Chart 59. SHAS Project: 260 Persons with AIDS at Grady Health System, 11/21/00 – 11/20/01

Characteristic	Total	Minority	White
Gender	n (%)	n (%)	n (%)
Male	205 (79)	176 (78)	29 (83)
Female	55 (21)	49 (22)	6 (17)
Race/ethnicity			
African-American	215 (83)	215 (96)	-
White	35 (13)	-	35 (100)
Other	3 (1)	3 (1)	-
Hispanic	7 (3)	7 (3)	-
Current marital status *			
Never married	176 (68)	148 (66)	28 (80)
Separated/divorced	64 (24)	57 (25)	7 (20)
Married/Widowed	20 (8)	20 (9)	-

*Common-law marriage is no longer included as a coding option for comparability with census bureau definitions

Chart 60. SHAS Project: 260 Persons with AIDS at Grady Health System, 11/21/00 – 11/20/01

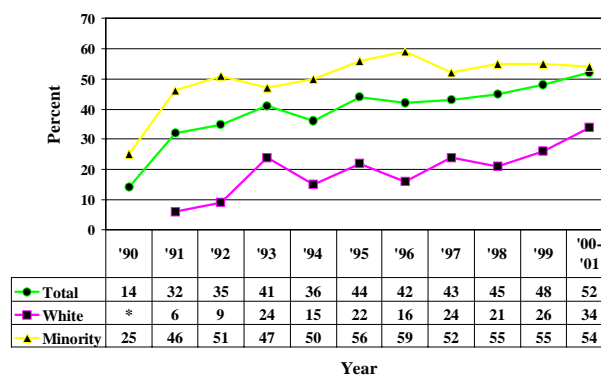
	Total	Minority	White
Education	n (%)	n (%)	n (%)
Completed high school or more	181 (70)	151 (67)	30 (86)
Source of financial support			
Salary or pension	38 (15)	32 (14)	6 (17)
Social Security	182 (70)	159 (71)	23 (66)
Public assistance or no income	21 (8)	20 (9)	1 (3)
Spouse, family or friends	19 (7)	14 (6)	5 (14)
Annual income			
< \$10,000	129 (50)	118 (52)	11 (31)
≥ \$10,000	128 (49)	104 (46)	24 (69)
Refused or unknown	3 (1)	3 (1)	-
Currently employed	62 (24)	51 (23)	11 (31)
Total	260 (100)	225 (100)	35 (100)

Chart 62. SHAS Project: Persons with AIDS at Grady Health System

Since you learned you were infected with HIV, has your job situation changed?

	Total	Minority	White
	n (%)	n (%)	n (%)
No change in job situation	85 (33)	78 (35)	7 (20)
Quit or laid off due to:			
• Illness	112 (43)	93 (41)	19 (54)
• Other reason	26 (10)	24 (11)	2 (6)
Changed jobs/returned to work	37 (14)	30 (13)	7 (20)
Total	260 (100)	225 (100)	35 (100)

Chart 63. SHAS Project: Persons with AIDS at Grady Health System
Have you ever used crack cocaine?



* For 1990, White n < 20, thus report of 0% may be unreliable and is not shown.

Chart 61. SHAS Project: Minority Persons with AIDS at Grady Health System (n = 225)
Type of Health Insurance and Current Living Situation

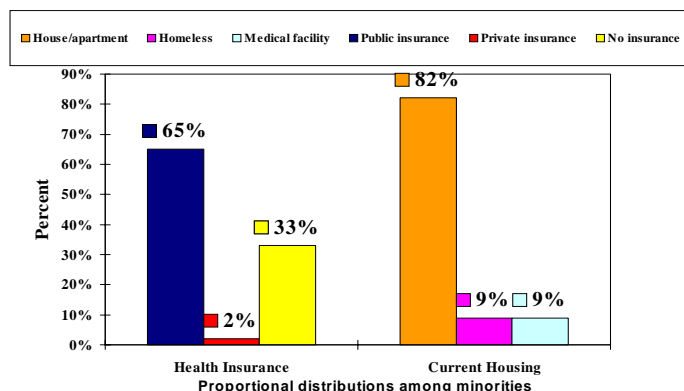
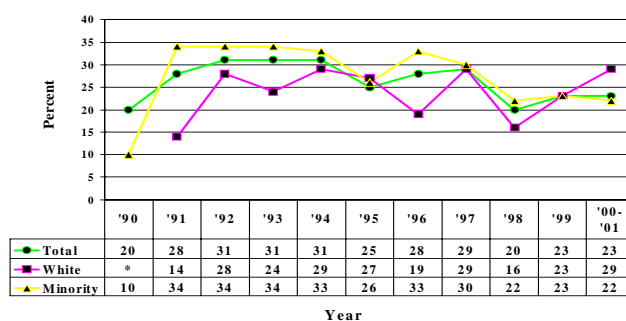


Chart 64. SHAS Project: Persons with AIDS at Grady Health System

Have you ever injected drugs with a needle?



* For 1990, White n < 20, thus report of 0% may be unreliable and is not shown.



Table 4. STD History and Sexual Behaviors among Minorities – 2000-2001 SHAS Project

Interviews at Grady	Minority % Responding Yes
Have you ever had genital, oral, pharyngeal or rectal gonorrhea?	58%
Have you ever had syphilis?	37%
Have you ever had chlamydia, non-gonococcal urethritis (NGU), non-specific urethritis (NSU), cervicitis, mucopurulent cervicitis (MPC), or Pelvic Inflammatory Disease?	14%
Have you ever had anal or genital warts?	15%
Have you ever had anal or genital herpes?	18%
Have you ever had any STD (other than HIV)?	77%
Has anyone ever given you money or drugs to have sex with them?	36%
Have you ever paid money or given drugs to anyone to have sex with you?	30%
How do you think you most likely got infected with HIV?	
MSM (men only)	35%
Heterosexual contact (men only)	27%
Heterosexual contact (women only)	16%
Sex with a bisexual man (women only)	1%
IDU	14%
Blood transfusion	3%
Don't know	2%
Other	1%
Refused	0%



Table 5. HIV Testing Behaviors of Minorities – 2000-2001 SHAS Project

Interviews at Grady

Where were you tested when you had your first positive HIV test?

<u>Type of Facility</u>	<u>Minority %</u>
Hospital (inpatient)	27%
Public health department, general medical, community health center, primary care clinic	19%
Correctional facility (jail, prison)	12%
Hospital (outpatient)	11%
Private physician, HMO, primary care clinic	4%
STD clinic	5%
AIDS or infectious disease clinic	4%
Emergency room	3%
Blood bank	4%
HIV counseling and testing site	3%
Drug treatment clinic	3%
Mobile test site	3%
Prenatal or obstetrics clinic	2%
School or college clinic	1%
Insurance or employee clinic	1%
Military clinic	0%

When you first tested positive for HIV, did someone else recommend you get tested, did you decide to get tested yourself, or was the test required?

Someone else recommended or suggested you get tested	45%
You decided to get tested yourself	37%
The test was required	18%

When you first tested positive for HIV, what type of test did you have?

Anonymous	12%
Confidential	84%
Don't know/not sure	4%



Ryan White Title I

Ryan White Title I is a federally funded program for eligible metropolitan areas (EMAs) that have been the most severely affected by the HIV epidemic. Ryan White Title I provides outpatient health and support services to people living with HIV/AIDS in the 20-county Atlanta EMA. These services include substance abuse and mental health treatment, support services, outpatient primary care, case management, home health and hospice care, nutrition services, and transportation.

Of the approximately 11,800 Ryan White Title I clients in the Atlanta EMA as of 2001, 68% were African-American, 27% were white, 4% were Hispanic/Latino, <1% were Asian/Pacific Islander, and <1% were American Indian/Alaska Native.

Tables 6-10 show demographic information, living status, homelessness, income and insurance status, CD4 counts, mode of HIV transmission, primary health care source, and TB status of white, African-American, Hispanic/Latino, Asian/Pacific Islander, and American Indian/Alaska Native Ryan White Title I clients.

Minority clients were more likely to be younger than white clients. Of the white clients, 52% were less than 40 years old; African-Americans 53%, Asians/Pacific Islanders 65%, American Indians/Alaska Natives 68%, and Hispanics/Latinos 68%.

The largest proportions of female clients were among African-Americans (28%), Asians/Pacific Islanders (28%), Hispanics/Latinos (24%), and American Indians/Alaska Natives (24%), compared to 13% among white clients.

Most of the homeless clients were African-American (1,189). A higher rate of people with incomes 300% below poverty was reported more among Asians/Pacific Islanders (90%), Hispanics/Latinos (94%), African-Americans (97%), American Indians/Alaska Natives (100%), than white clients (88%). White clients were more likely to use private insurance than African-Americans or Hispanics.

Heterosexual contact and men who have sex with men (MSM) were the primary modes of HIV exposure for African-Americans, Hispanics/Latinos, Asians/Pacific Islanders, American Indians/Alaska Natives, and white clients.

The most common primary health care sources for white clients were public-funded community health centers (50%) and private practices (19%). Public-funded community health centers were the primary health care sources for 60% of the African-American clients, 59% for Hispanic clients, 64% for Asian/Pacific Islander clients, and 52% for American Indian/Alaska Native clients.



**Table 6. White (Non-Hispanic) Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001**

Characteristic	Number	Percent
Age group		
Less than 13	11	.34%
13 - 19	88	3%
20 - 24	44	1%
25 - 29	164	5%
30 - 34	464	14%
35 - 39	896	28%
40 - 44	909	28%
45 - 49	329	10%
50 - 54	159	5%
55 and over	151	5%
Gender		
Male	2,786	87%
Female	429	13%
Living Status		
Active	3,135	98%
Deceased	80	2%
Homeless		
Yes	176	5%
No	3,039	95%
Income (Below 300% of poverty)		
Yes	2,834	88%
No	381	12%
Payor/insurance status (will not sum to 100%)		
Private insurance	420	13%
Medicaid	383	12%
Other public insurance	459	14%
Answered unknown for all questions	205	6%
CD4 plus lymphocyte (T-cell) count		
Less than 100	218	7%
100 – 199	297	9%
200 – 499	1,000	31%
500 or more, if adult	684	21%
500 – 750, if pediatric	0	0%
751 – 1500, if pediatric	<5	<1%
Not applicable/never been tested	619	19%
Unknown	395	12%



**Table 6. White (Non-Hispanic) Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001 (continued)**

Characteristic	Number	Percent
Mode of Transmission		
Men who have sex with men	1,844	57%
Transfusion of blood	23	.72%
Injection drug use	78	2%
Heterosexual males/IDU	32	1%
Heterosexual females/IDU	25	1%
Men who have sex w/men and IDU	72	2%
Bisexual males/IDU	11	.34%
Bisexual males	79	2%
Heterosexual contact	386	12%
Pediatric/not applicable	182	6%
Provider didn't ask	427	13%
Unknown	56	2%
Primary health care source		
Solo/group private practice, not HMO	616	19%
HMO	119	4%
Public-funded community health center	1,596	50%
Hospital outpatient clinic/department	97	3%
Emergency room	<5	<1%
VA or military hospital, OP or Dept.	25	.78%
Other public clinic or department	304	9%
Other private community based organization	65	2%
Other	25	.78%
None	73	2%
Unknown	225	7%
TB status		
Active	10	.31%
Inactive	71	2%
No TB	1,445	45%
Not applicable	38	1%
Unknown	1,160	36%
Total		
White (non-Hispanic)	3,216 – 3,219	100%



**Table 7. African-American (Non-Hispanic) Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001**

Characteristic	Number	Percent
Age group		
Less than 13	113	1%
13 - 19	73	1%
20 - 24	254	3%
25 - 29	622	8%
30 - 34	1,141	14%
35 - 39	2,074	26%
40 - 44	1,970	25%
45 - 49	908	11%
50 - 54	489	6%
55 and over	384	5%
Gender		
Male	5,766	72%
Female	2,260	28%
Other	<5	<1%
Living Status		
Active	7,785	97%
Deceased	243	3%
Homeless		
Yes	1,189	15%
No	6,821	85%
Income (Below 300% of poverty)		
Yes	7,783	97%
No	245	3%
Payor/insurance status (will not sum to 100%)		
Private insurance	420	5%
Medicaid	2,008	25%
Other public insurance	760	9%
Answered unknown for all questions	574	7%
CD4 plus lymphocyte (T-cell) count		
Less than 100	982	12%
100 – 199	916	11%
200 – 499	2,507	31%
500 or more, if adult	1,689	21%
500 – 750, if pediatric	<5	<1%
751 – 1500, if pediatric	8	.10%
Not applicable/never been tested	991	12%
Unknown	926	12%



**Table 7. African-American (Non-Hispanic) Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001 (continued)**

Characteristic	Number	Percent
Mode of Transmission		
Men who have sex with men	2,293	29%
Transfusion of blood	56	.70%
Injection drug use	315	4%
Heterosexual males/IDU	303	4%
Heterosexual females/IDU	160	2%
Men who have sex w/men and IDU	82	1%
Bisexual males/IDU	79	1%
Bisexual males	473	6%
Heterosexual contact	3,070	38%
Pediatric/not applicable	568	7%
Provider didn't ask	544	7%
Unknown	85	1%
Primary health care source		
Solo/group private practice, not HMO	443	6%
HMO	116	1%
Public-funded community health center	4,835	60%
Hospital outpatient clinic/department	472	6%
Emergency room	5	.06%
VA or military hospital, OP or Dept.	77	1%
Other public clinic or department	855	11%
Other private community based organization	154	2%
Other	40	.50%
None	220	3%
Unknown	580	7%
TB status		
Active	132	2%
Inactive	525	7%
No TB	4,415	55%
Not applicable	35	.44%
Unknown	2,216	26%
Total		
African-American (non-Hispanic)	8,029 – 8,032	100%



**Table 8. Hispanic Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001**

Characteristic	Number	Percent
Age group		
Less than 13	6	1%
13 - 19	5	1%
20 - 24	17	4%
25 - 29	68	15%
30 - 34	79	18%
35 - 39	131	29%
40 - 44	76	17%
45 - 49	34	8%
50 - 54	20	5%
55 and over	11	2%
Gender		
Male	340	76%
Female	107	24%
Living Status		
Active	439	98%
Deceased	8	2%
Homeless		
Yes	32	7%
No	415	93%
Income (Below 300% of poverty)		
Yes	421	94%
No	21	5%
Payor/insurance status (will not sum to 100%)		
Private insurance	20	5%
Medicaid	58	13%
Other public insurance	50	11%
Answered unknown for all questions	21	5%
CD4 plus lymphocyte (T-cell) count		
Less than 100	40	9%
100 – 199	45	10%
200 – 499	134	30%
500 or more, if adult	93	21%
751 – 1500, if pediatric	0	0%
Not applicable/never been tested	94	21%
Unknown	40	9%



**Table 8. Hispanic Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001 (continued)**

Characteristic	Number	Percent
Mode of Transmission		
Men who have sex with men	145	32%
Transfusion of blood	<5	<1%
Injection drug use	12	3%
Heterosexual males/IDU	<5	<1%
Heterosexual females/IDU	<5	<1%
Men who have sex w/men and IDU	5	1%
Bisexual males/IDU	0	0%
Bisexual males	17	4%
Heterosexual contact	180	40%
Pediatric/not applicable	18	4%
Provider didn't ask	56	13%
Unknown	<5	<1%
Primary health care source		
Solo/group private practice, not HMO	20	5%
HMO	10	2%
Public-funded community health center	264	59%
Hospital outpatient clinic/department	22	5%
Emergency room	<5	<1%
VA or military hospital, OP or Dept.	<5	<1%
Other public clinic or department	46	10%
Other private community based organization	11	2%
Other	<5	<1%
None	43	10%
Unknown	23	5%
TB status		
Active	6	1%
Inactive	19	4%
No TB	240	54%
Not applicable	8	2%
Unknown	100	22%
Total		
Hispanic	448 –451	100%



**Table 9. Asian/Pacific Islander Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001**

Characteristic	Number	Percent
Age group		
Less than 13	0	0%
13 - 19	<5	<2%
20 - 24	7	10%
25 - 29	10	14%
30 - 34	18	26%
35 - 39	10	14%
40 - 44	14	20%
45 - 49	<5	<7%
50 - 54	<5	<5%
55 and over	<5	<4%
Gender		
Male	50	72%
Female	19	28%
Living Status		
Active	69	100%
Deceased	0	0%
Homeless		
Yes	<5	<4%
No	67	97%
Income (Below 300% of poverty)		
Yes	62	90%
No	7	10%
Payor/insurance status (will not sum to 100%)		
Private insurance	6	9%
Medicaid	10	14%
Other public insurance	8	12%
Answered unknown for all questions	<5	<2%
CD4 plus lymphocyte (T-cell) count		
Less than 100	10	14%
100 – 199	5	7%
200 – 499	21	30%
500 or more, if adult	13	19%
500 – 750, if pediatric	0	0%
751 – 1500, if pediatric	0	0%
Not applicable/never been tested	17	25%
Unknown	<5	<5%



**Table 9. Asian/Pacific Islander Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001 (continued)**

Characteristic	Number	Percent
Mode of Transmission		
Men who have sex with men	31	45%
Transfusion of blood	0	0%
Injection drug use	<5	<2%
Heterosexual males/IDU	<5	<2%
Heterosexual females/IDU	0	0%
Men who have sex w/men and IDU	0	0%
Bisexual males/IDU	0	0%
Bisexual males	8	12%
Heterosexual contact	19	28%
Pediatric/not applicable	0	0%
Provider didn't ask	9	13%
Unknown	0	100%
Primary health care source		
Solo/group private practice, not HMO	9	13%
HMO	<5	<2%
Public-funded community health center	44	64%
Hospital outpatient clinic/department	<5	<4%
Emergency room	0	0%
VA or military hospital, OP or Dept.	0	0%
Other public clinic or department	8	12%
Other private community based organization	<5	<2%
Other	0	0%
None	<5	<5%
Unknown	0	0%
TB status		
Active	0	0%
Inactive	6	9%
No TB	35	51%
Not applicable	<5	<2%
Unknown	17	25%
Total		
Asian/Pacific Islander	70 -73	100%



**Table 10. American Indian/Alaska Native Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001**

Characteristic	Number	Percent
Age group		
Less than 13	0	0%
13 - 19	0	0%
20 - 24	0	0%
25 - 29	5	20%
30 - 34	<5	<17%
35 - 39	8	32%
40 - 44	5	20%
45 - 49	<5	<9%
50 - 54	0	0%
55 and over	<5	<5%
Gender		
Male	19	76%
Female	6	24%
Living Status		
Active	24	96%
Deceased	<5	<5%
Homeless		
Yes	6	24%
No	19	76%
Income (Below 300% of poverty)		
Yes	25	100%
No	0	0%
Payor/insurance status (will not sum to 100%)		
Private insurance	<5	<13%
Medicaid	6	24%
Other public insurance	<5	<9%
Answered unknown for all questions	0	0%
CD4 plus lymphocyte (T-cell) count		
Less than 100	<5	<9%
100 – 199	<5	<17%
200 – 499	<5	<17%
500 or more, if adult	<5	<13%
500 – 750, if pediatric	0	0%
751 – 1500, if pediatric	0	0%
Not applicable/never been tested	7	28%
Unknown	5	20%



**Table 10. American Indian/Alaska Native Ryan White Title I clients in the Atlanta EMA
January 2001 – December 2001 (continued)**

Characteristic	Number	Percent
Mode of Transmission		
Men who have sex with men	13	52%
Transfusion of blood	<5	<9%
Injection drug use	0	0%
Heterosexual males/IDU	0	0%
Heterosexual females/IDU	0	0%
Men who have sex w/men and IDU	<5	<5%
Bisexual males/IDU	0	0%
Bisexual males	<5	<13%
Heterosexual contact	<5	<17%
Pediatric/not applicable	0	0%
Provider didn't ask	<5	<9%
Unknown	0	0%
Primary health care source		
Solo/group private practice, not HMO	<5	<13%
HMO	<5	<5%
Public-funded community health center	13	52%
Hospital outpatient clinic/department	<5	<9%
Emergency room	0	0%
VA or military hospital, OP or Dept.	0	0%
Other public clinic or department	<5	<9%
Other private community based organization	<5	<9%
Other	0	0%
None	<5	<9%
Unknown	0	0%
TB status		
Active	0	0%
Inactive	0	0%
No TB	9	36%
Not applicable	0	0%
Unknown	11	44%
Total		
American Indian/Alaska Native	26 -29	100%



Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is a random digit and dial annual survey that is conducted by telephone with people at least 18 years old in Georgia. The survey focuses on health-related questions, and HIV/AIDS-related questions are asked of persons 18-64 years old. Households without telephones or that use cell phones exclusively are not included. In 2001, 3,848 adults ages 18 – 64 were included in the survey. The sample is weighted to the age, sex, and race distributions for the state to provide estimates for the whole population.

The percentage of adults 18-64 years old tested for HIV has increased each year from 26% in 1993 to 55% in 2001 ([Chart 65](#)). From 1993 – 2001, the percentage of minorities tested for HIV has increased each year from 31% to 63%. Among blacks surveyed, 66% tested for HIV in 2001, compared to 50% of whites, 64% of Hispanics, and 48% of adults of other races or ethnicities ([Chart 66](#)).

Pregnancy and HIV knowledge

Treating a pregnant woman infected with HIV with antiretroviral medications can significantly reduce the chances that she will pass the virus to her baby. The majority of African-American (62%) respondents reported that it was true that a pregnant woman with HIV can get treatment to help reduce the chances that she will pass the virus on to her baby, compared to 55% of whites

surveyed, 52% of people in other racial or ethnic groups, and 47% of Hispanics ([Chart 67](#)).

Medical Treatment and HIV infection

With modern therapies, death rates from AIDS have fallen dramatically and many HIV-infected persons are living longer. Research is being conducted on the side effects of the antiretroviral drugs and the development of more effective medications. According to the survey, 89% of whites believed that there are medical treatments available that are intended to help a person who is infected with HIV to live longer, along with 83% of blacks, 85% of Hispanics, and 71% of people in other racial or ethnic groups ([Chart 68](#)).

HIV Treatment Effectiveness

Among white respondents, 84% felt that these treatments were very effective or some what effective in helping persons with HIV to live longer, compared to 82% of blacks, 79% of Hispanics, and 81% of other racial or ethnic groups ([Chart 69](#)).

Self-perceived HIV risk among minorities surveyed for the BRFSS in Georgia in 2000 is shown in [Table 11](#).

Characteristics of minorities surveyed for the BRFSS in Georgia in 2001 are shown in [Table 12](#).



**Chart 65. Have You Ever Had Blood Tested for HIV/AIDS?
BRFSS 1993-2001**

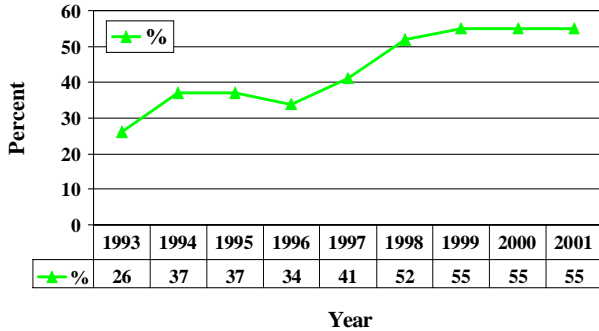
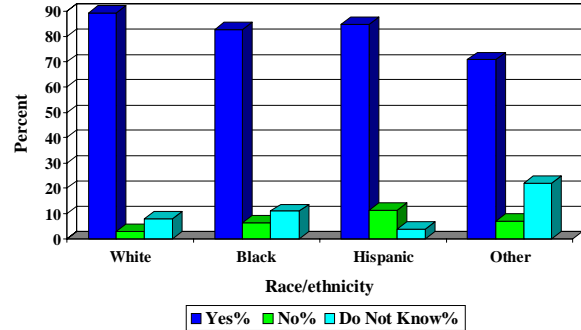


Chart 68. “There are medical treatments available that are intended to help a person who is infected with HIV to live longer.”-BRFSS 2001



**Chart 66. Have You Ever Had Blood Tested for HIV/AIDS?
Among Minority and all Race/Ethnicities
BRFSS 1993-2001**

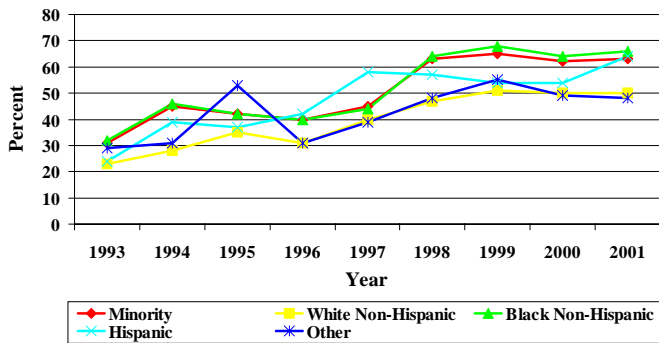


Chart 69. “How effective do you think these treatments are in helping persons with HIV to live longer?”-BRFSS 2001

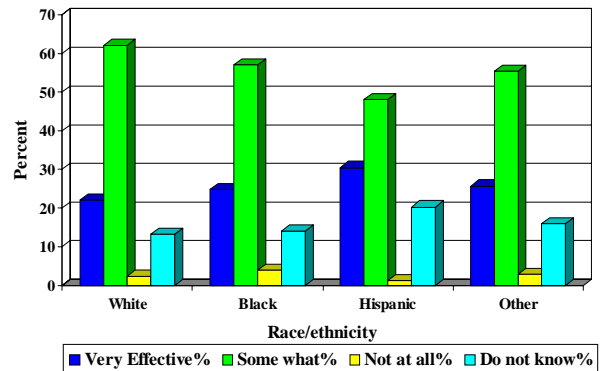
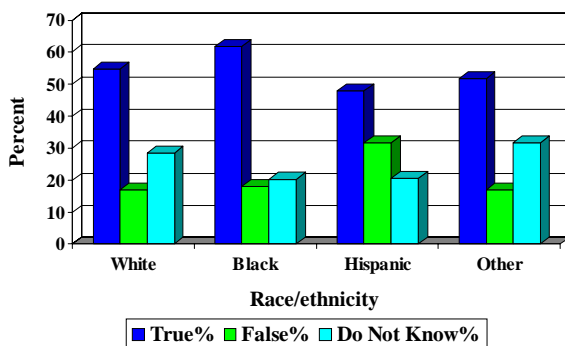


Chart 67. “A pregnant woman with HIV can get treatment to help reduce the chances that she will pass the virus on to her baby.”-BRFSS 2001



**Table 11. Self Perceived HIV Risk among Minorities, Aged 18 to 64 Years,
Interviewed for the Georgia 2000 BRFSS Study**

	Low/Med./ High N	Wt. %	None N	Wt. %	Total* N	Wt. %
Age Group						
18-29	130	36.6	159	30.8	289	32.8
30-39	132	34.7	173	22.7	305	26.9
40-49	68	14.0	192	27.3	260	22.7
50-64	56	14.7	149	19.2	205	17.6
Sex						
Female	252	53.8	463	51.8	715	52.5
Male	135	46.2	221	48.2	356	47.5
Race						
Black	349	87.7	604	85.6	953	86.4
Other	35	12.3	64	14.4	99	13.6
Ethnicity						
Hispanic	22	8.9	36	8.2	58	8.5
Non-Hispanic	360	91.1	634	91.8	994	91.5
County of Residence						
20-County Atlanta	150	50.0	268	48.3	418	48.9
Rural	228	50.0	407	51.7	635	51.1
Highest Level of Education						
< High School	40	10.0	89	12.4	129	11.6
High School or More	347	90.0	591	87.6	938	88.4
Annual Household Income						
< \$ 15,000	59	12.7	105	13.8	164	13.4
\$15,000 or more	291	87.3	479	86.2	770	86.6
Ever Tested HIV						
Yes	290	73.4	403	58.4	693	63.7
No	92	26.6	252	41.6	344	36.3
Have you been tested for HIV within the last 12 months, excluding blood donation?						
Yes	130	29.0	195	30.9	325	30.2
No	248	71.0	459	69.1	707	69.8
If tested for HIV within last 12 months did you receive the results?						
Yes	119	91.7	173	89.0	292	89.9
No	10	8.3	18	11.0	28	10.1
If tested for HIV within last 12 months and received results, did you receive counseling about the result?						
Yes	43	40.8	63	33.6	106	36.1
No	76	59.2	109	66.4	185	63.9

* Table includes persons of Hispanic ethnicity or non-white race. White, non-Hispanics were excluded.



**Table 12. Characteristics of Minorities, Aged 18 to 64 Years,
Interviewed for the Georgia 2001 BRFSS Study**

	Number	Wt. %
Age Group		
18-29	301	29.9
30-39	389	29.1
40-49	337	23.5
50-64	247	17.5
Sex		
Female	842	50.7
Male	454	49.3
Race		
Black	1059	80.2
Other	195	19.8
Ethnicity		
Hispanic	46	4.5
Non-Hispanic	1243	95.5
County of Residence		
20-County Atlanta	527	50.6
Rural	735	49.4
Highest Level of Education		
< High School	184	15.5
High School or More	1106	84.5
Annual Household Income		
< \$ 15,000	173	13.3
\$15,000 or more	950	86.7
Have you ever been tested for HIV, excluding blood donations?		
Yes	792	63.0
No	421	36.9



Adult Spectrum of Disease Study (ASD)

The Adult Spectrum of Disease Study (ASD) is a national surveillance project of the Centers for Disease Control and Prevention (CDC) conducted in 11 US cities. In Georgia, the ASD Study is conducted by the AIDS Research Consortium of Atlanta (ARCA). For this study, data are abstracted over time from clinical charts of HIV/AIDS patients and are used to study broad trends in the HIV/AIDS epidemic. ARCA was involved in the original design of the ASD study, and has enrolled more than 9,900 patients since the study began in 1990. Over 56,000 patients have been enrolled nationwide.

ARCA has analyzed ASD data to address scientific and public health issues, and has presented findings at national and international conferences. ASD data are used to illustrate trends in the incidence of various HIV-related illnesses across time, and to describe possible associations between prescribed treatments and disease progression. ASD data are also used to identify potential risk factors for developing certain HIV-related conditions.

The limitations in using data from the ASD study must be considered. ASD includes a large, diverse, and sampled population of HIV-infected persons that is similar to metropolitan Atlanta HIV/AIDS population by race and sex, but it does not represent the entire metropolitan Atlanta population of persons with HIV/AIDS.

ASD includes diverse study sites and populations, but these data are not necessarily representative of all HIV-infected persons. Patients are enrolled in the study according to a sampling plan based on race and gender. Therefore the absolute numbers of patients in ASD do not constitute the total number of patients in care at any site. Because HIV-infected patients must be receiving medical care at a facility to be enrolled, there may be a selection bias among asymptomatic people for inclusion of those with earlier knowledge of HIV infection status, or with more access to medical care.

From 1990 – 2002, 9,922 persons with HIV/AIDS were enrolled in the ASD Study by ARCA. Of those enrolled 57% were African-American, 39% were white, 3% were Hispanic, and 0.5% were Other.

Cumulatively the Atlanta ASD Study includes more black/African-American persons with both HIV and AIDS when compared to other race/ethnicities ([Chart 70](#)).

A higher proportion of blacks/African-Americans with HIV/AIDS receives care from public sites than private sites ([Chart 71](#)).

Blacks/African-Americans are the predominant minority population in both the public and the private care sites ([Chart 72](#)).

Blacks/African-Americans compose the majority (93%) of the minority distribution of ASD patients in private care ([Chart 73](#)).

Blacks/African-Americans also compose the majority (96%) of the minority distribution of ASD patients in public care ([Chart 74](#)).

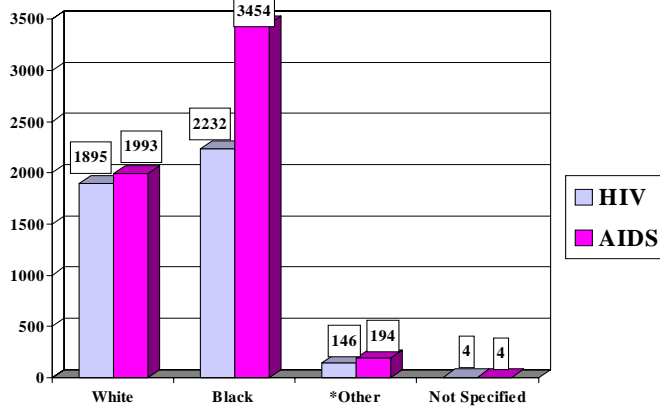
Men who have sex with men (MSM) constitute 52% of the sum total for modes of HIV transmission among minority males. At this time, 22% of these men have HIV and 30% have AIDS ([Chart 75](#)).

‘Undetermined’ mode of HIV transmission comprises 51% of the sum total for modes of HIV transmission for minority females. At this time, 22% of these women have HIV and 29% have AIDS ([Chart 76](#)).

For the enrolled HIV patients, the majority of both of the black/African-American and white patients are receiving their care from private physicians. For the enrolled AIDS patients, the majority of blacks/African-Americans receive care at public sites and the majority of whites are receiving care at private sites ([Chart 77](#)).



Chart 70. ASD Study: Persons with HIV vs. AIDS¹ by Race
9,922 patients enrolled, 1990 - 2002

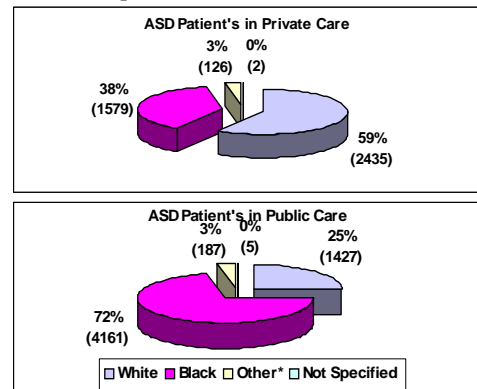


*Other = Hispanic, Asian/Pacific Islander, Am. Indian/Alaskan, Other

¹CDC's 1993 AIDS Case Definition

#The ASD Study does not include all patients in care. Patients are enrolled in the study based on race & gender.

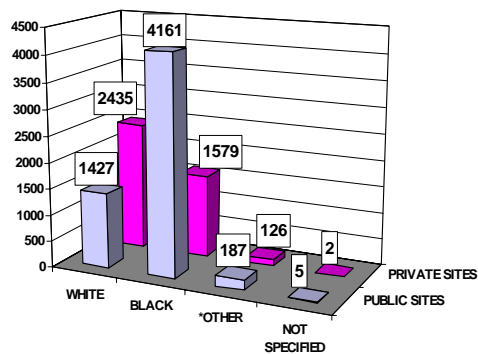
Chart 72. ASD Study: Site of Care (Public vs. Private) by Race
9,922 patients enrolled, 1990 - 2002



*Other = Hispanic, Asian/Pacific Islander, Am. Indian/Alaskan, Other

#The ASD Study does not include all patients in care. Patients are enrolled in the study based on race & gender.

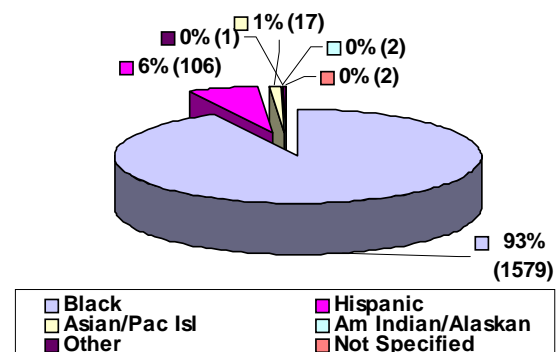
Chart 71. ASD Study: Site of Care (Public vs. Private) by Race
9,922 patients enrolled, 1990 - 2002



*Other = Hispanic, Asian/Pacific Islander, Am. Indian/Alaskan, Other

#The ASD Study does not include all patients in care. Patients are enrolled in the study based on race & gender.

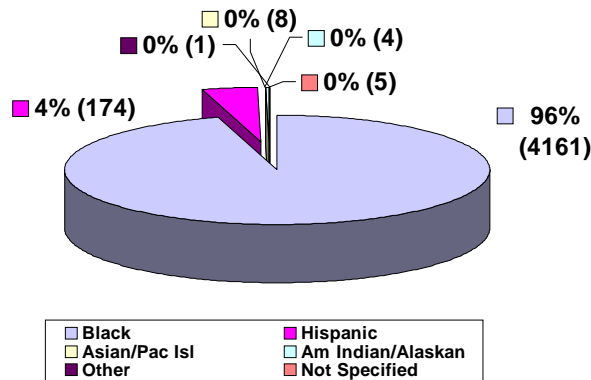
Chart 73. ASD Study: Minority Distribution of ASD Patients in Private Care
1990 - 2002



#The ASD Study does not include all patients in care. Patients are enrolled in the study based on race & gender.

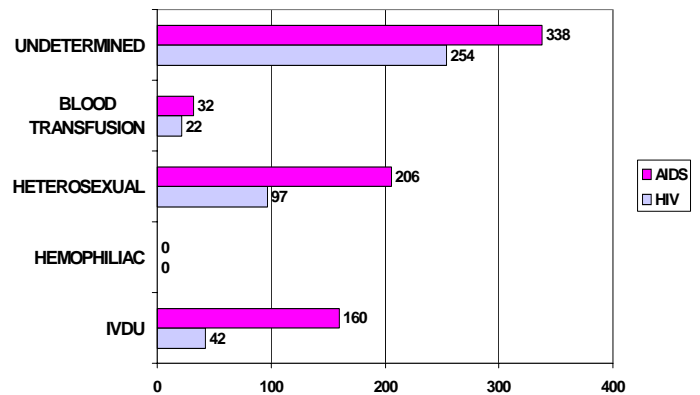


**Chart 74. ASD Study:
Minority Distribution of ASD Patients in Public Care
1990 - 2002**



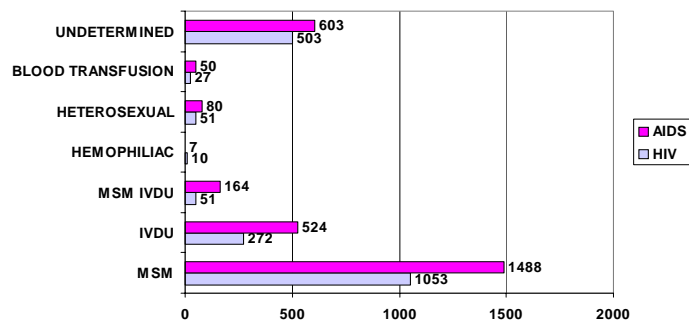
#The ASD Study does not include all patients in care. Patients are enrolled in the study based on race & gender.

**Chart 76. ASD Study: Mode of HIV Transmission for
Minority Females
1990 - 2002**



#The ASD Study does not include all patients in care. Patients are enrolled in the study based on race & gender.

**Chart 75. ASD Study: Mode of HIV Transmission for
Minority Males
1990 - 2002**



#The ASD Study does not include all patients in care. Patients are enrolled in the study based on race & gender.

**Chart 77. ASD Study: Public/Private Care
and AIDS Status by Race
1990 - 2002**

RACE ¹	HIV			AIDS ²		
	PUBLIC SITES ³	PRIVATE SITES ⁴	HIV TOTALS	PUBLIC SITES ³	PRIVATE SITES ⁴	AIDS TOTALS
WHITE (NOT HISPANIC)	294 (25.02%)	1601 (51.61%)	1895 (44.31%)	812 (14.38%)	1181 (20.92%)	1993 (46.60%)
BLACK (NOT HISPANIC)	844 (71.83%)	1388 (44.75%)	2232 (52.19%)	2612 (46.27%)	842 (14.92%)	3454 (80.76%)
HISPANIC	34 (2.89%)	92 (2.97%)	126 (2.95%)	119 (2.11%)	54 (0.96%)	173 (4.04%)
ASIAN / PACIFIC ISL.	0 (0%)	16 (0.52%)	16 (0.37%)	6 (0.11%)	11 (0.19%)	17 (0.40%)
AM. INDIAN / ALASKAN	1 (0.09%)	2 (0.06%)	3 (0.07%)	3 (0.05%)	0 (0%)	3 (0.07%)
OTHER	0 (0%)	1 (0.03%)	1 (0.02%)	1 (0.02%)	0 (0%)	1 (0.02%)
NOT SPECIFIED	2 (0.17%)	2 (0.06%)	4 (0.09%)	3 (0.05%)	1 (0.02%)	4 (0.09%)
TOTAL	1175 (27.47%)	3102 (72.53%)	4277 (100%)	3556 (62.99%)	2089 (37.01%)	5645 (100%)

*Percents are column percents except for Total rows.

¹Race/Ethnicity

²CDC's 1993 AIDS Case Definition

³Public Sites = Grady Infectious Disease Clinic and Veteran Medical Administration Center

⁴Private Sites = Private Physicians in ARCA's Consortium

#The ASD Study does not include all patients in care. Patients are enrolled in the study based on race & gender.



Georgia Department of Corrections (GDC)

The mission of the Georgia Department of Corrections is to protect the public, serve victims of crime and reduce crimes committed by sentenced offenders by holding offenders accountable and providing safe and secure facilities, effective community supervision, and effective methods of self-improvement for offenders.

There were over 44,000 prison inmates in Georgia correctional facilities as of FY 2001¹¹. There was a 104% population increase in prisoners in Georgia from 1991 to 2001. From 1991 to 2001, the growth rate was 132% for females, while the male inmate population increased 96%. Females are now 6% of the inmates in Georgia. Over half of female prisoners are non-white.

Georgia ranked number one nationally in 1998 and 2000 for inmate population growth and second in 1999¹¹. The number of prisoners is expected to reach 50,000 by July 2004 in Georgia. Georgia is fifth highest in the rate of incarceration (550 per 100,000) in the United States after Louisiana, Texas, Mississippi, and Oklahoma¹¹. Georgia is eighth in the nation in the total number of inmates.

The proportion of African-Americans in Georgia prisons has remained unchanged since 1991. In 1991 and 2001, African-Americans were 66% and whites were 34% of the inmate population.

Testing for HIV is mandatory upon prison intake and is also offered at an inmate's periodic physical exam. Inmates with HIV are provided with chronic care clinic visits every 3 months, consultation with an infectious disease physician,

access to and monitoring of antiretroviral medications, a scheduled medical appointment in the community before release, and 30 days of highly active antiretroviral therapy (HAART) at release. There is currently one education and support group for HIV-infected women at Metro State Prison.

The number of HIV positive inmates admitted to and released by the Georgia Department of Corrections (GDC) each year from 1991 to 2001 has been relatively stable with the exception of African-American males. Overall, the number of African-American male inmates admitted and released with HIV has declined from 1991 to 2001 ([Charts 78-79](#)).

Of the 18,064 individuals admitted to state prisons in Georgia in 2001, 398 or 2.2% tested positive for HIV at intake. Among males, 2% tested positive at intake, while 3.5% of females tested positive. These numbers do not necessarily represent new HIV diagnoses.

Of the 965 male prisoners living with HIV or AIDS as of May 2002, 859 (89%) are African-American, 104 (11%) are white, and 2 (<1%) are "Other" race/ethnicity. Of the 115 female prisoners living with HIV or AIDS, 99 (86%) are African-American, and 16 (14%) are white. Approximately 65% of inmates with HIV/AIDS are on HAART.

The disproportionate number of minorities incarcerated with HIV and AIDS in Georgia provides an opportunity to address HIV/AIDS in Georgia prisons.

Chart 78. Inmates Admitted with HIV in Georgia, 1992 – 2001
by race/ethnicity and sex

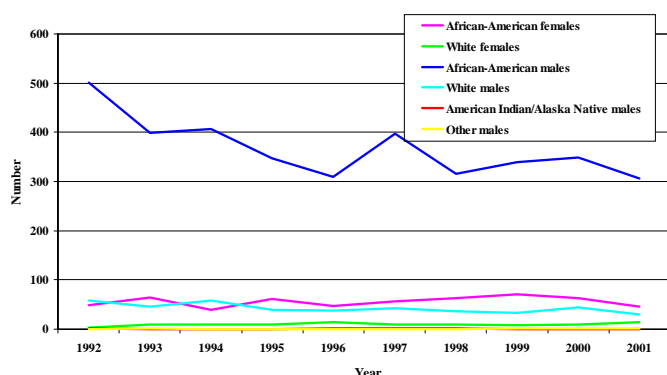
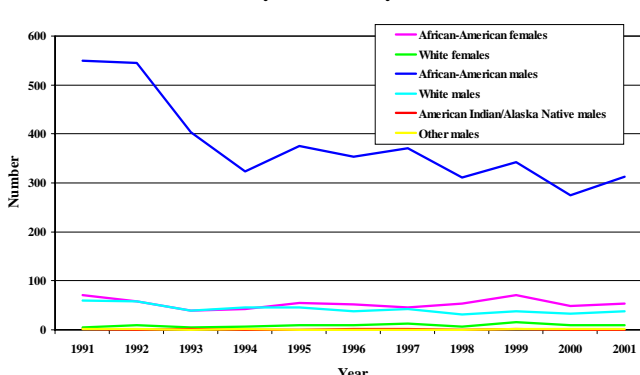


Chart 79. Inmates Released with HIV in Georgia, 1991 – 2001
by race/ethnicity and sex





STD Surveillance

The testing and treatment of sexually transmitted diseases (STDs) is an effective way of reducing the risk of HIV infection in communities, especially communities of color¹². An individual with an STD is two to five times more likely to acquire HIV through sexual contact than uninfected individuals because of increased susceptibility. Moreover, a person with HIV and an STD is more infectious during sexual contact than individuals with HIV who do not have an additional STD.

There are at least 65 million people in the United States living with an incurable sexually transmitted disease and 15 million people become infected with one or more STDs each year¹³. Of the 15 million people who become infected each year, one fourth are teenagers. Excluding HIV, chlamydia, gonorrhea, and syphilis are the most common STDs in the United States.

While the number of individuals with an STD such as syphilis has declined dramatically overall in the U.S., others like genital herpes, gonorrhea, and chlamydia have multiplied in the community¹³. Although syphilis rates are at an all time low nationally, high rates of syphilis continue in many areas in the United States, primarily in the South.

There were 50% more primary and secondary syphilis cases among males than females in 1999¹³. The male to female syphilis ratio growth in 1999 was caused by the increase of men who have sex with men with syphilis in specific locations in the United States. This increase among MSM may be associated with a change in sexual behaviors because of the availability of antiretroviral medications for HIV patients.

Gonorrhea rates declined 72% from 1975 to 1997, however rates of gonorrhea increased 9% from 1997 to 1999¹³. It should be noted that the number of STDs reported represents the efficiency and effectiveness of STD surveillance data sent to the CDC from state health departments, as well as the number of cases in a given population.

The top five cities in the United States with a population over 200,000 for reported gonorrhea cases in 1999 were 1) Baltimore, Maryland 2) Richmond, Virginia 3) St. Louis, Missouri 4) Rochester, New York and 5) Atlanta, Georgia¹³. The top five cities in the United States with a population over 200,000 for reported syphilis cases in 1999 were 1) Indianapolis, Indiana 2) Nashville, Tennessee 3) Baltimore, Maryland 4) Memphis, Tennessee and 5) Atlanta, Georgia. Many of these cities are located in states where chlamydia positivity rates were more than 5 percent among 15 to 24 year old females in family planning clinics in 1999.

The STD Surveillance Section in the Georgia Division of Public Health collects reports of STDs in Georgia. STD data are analyzed and interpreted to provide information that can be used to target high-risk populations. The primary functions of this unit include: 1) the collection, analysis, interpretation, and distribution of health data, 2) studying trends in STDs, based on reports submitted by physicians, laboratories, and health care providers, 3) assist programs in planning, implementing, and evaluating action plans to intervene in the spread of STDs, and 4) to monitor district health units for compliance with state guidelines for data collection and to provide technical assistance on case management to district staff. It should be noted that Tables 13-14 show a large number of chlamydia and gonorrhea cases with unknown race/ethnicity in 2001 in Georgia.

In 2001, the highest number of chlamydia infections in Georgia for racial and ethnic groups were among African-Americans and people 15 – 19 years old had the highest number of cases for all age groups ([Table 13](#)).

Gonorrhea cases were reported most in African-Americans for each racial and ethnic group in 2001 in Georgia and people 20 – 24 years old reported the highest number of cases for all age groups ([Table 14](#)).

In 2001, the highest number of syphilis infections in Georgia for racial and ethnic groups were among African-Americans and people 30 – 39 years old reported the highest number of cases for all age groups ([Table 15](#)).



Table 13. Chlamydia Infection in Georgia in 2001
by age group and race/ethnicity

	American Ind/AN	Asian/ PI	Black	White	Hispanic	Other	Unkown	Total
Age								
<=14	2	2	396	73	10	0	383	866
15 - 19	20	46	5,541	1,279	183	38	5,576	12,683
20 - 24	14	70	4,858	1,050	290	22	5,546	11,850
25 - 29	2	15	1600	280	179	8	2,254	4,338
30 - 39	3	20	896	166	91	7	1,403	2,586
40 - 49	0	4	182	30	14	2	269	501
50 - 59	0	0	38	5	1	1	46	91
>=60	2	2	79	27	13	0	361	484
Total	43	159	13,590	2,910	781	78	15,838	33,399

Table 14. Gonorrhea Infection in Georgia in 2001
by age group and race/ethnicity

	American Ind/AN	Asian/ PI	Black	White	Hispanic	Other	Unknown	Total
Age								
<=14	2	2	182	33	1	0	154	374
15 - 19	6	21	2801	271	33	12	2,235	5,379
20 - 24	7	23	3,134	267	42	13	2,397	5,883
25 - 29	3	5	1,480	119	31	1	1,244	2,883
30 - 39	3	5	1,209	137	21	5	1,212	2,592
40 - 49	2	3	493	63	11	2	488	1,062
50 - 59	0	1	114	14	2	0	107	238
>=60	0	1	67	7	3	0	186	264
Total	23	61	9,480	911	144	33	8,023	18,675



**Table 15. Syphilis Infection in Georgia in 2001
by age group and race/ethnicity**

	American Ind/AN	Asian/ PI	Black	White	Hispanic	Other	Unknown	Total
Age								
<=14	0	0	22	3	4	0	1	30
15 - 19	0	0	50	3	5	0	2	60
20 - 24	0	2	128	7	18	1	8	164
25 - 29	2	3	167	16	32	1	14	235
30 - 39	0	9	532	65	50	2	64	722
40 - 49	0	6	395	34	26	0	50	511
50 - 59	0	3	133	23	5	0	10	174
>=60	0	0	55	10	4	0	8	77
Total	2	23	1,482	161	144	4	157	1,973



HIV Prevention, Treatment, and Care in Georgia

STD/HIV Prevention Section/Georgia Division of Public Health

In an effort to present a more comprehensive picture of the impact of HIV/AIDS among minorities, it is necessary to look beyond the analyses available through the AIDS surveillance databases. This analysis is of greater significance in Georgia because currently HIV reporting is not mandatory in this state. This section of the report provides a presentation of information on minority participation in some programmatic aspects or components of Georgia's HIV/AIDS service delivery system.

This section is not intended to convey a comprehensive analysis of all public and quasi-public entities funded to provide HIV/AIDS programmatic efforts in Georgia. Those selected for inclusion in this report provide a significant sampling of a cross-section of such entities. As such, they provide important insight into the larger picture of the impact of HIV/AIDS among minorities in that their data reflects their service not only to persons living with AIDS but also those persons who are HIV infected but not diagnosed with AIDS.

The STD/HIV Prevention Section in the Georgia Division of Public Health (DPH), Department of Human Resources (DHR) is responsible for support and technical assistance to health districts, counties, and other related organizations by providing the following:

- HIV and STD testing
- HIV and STD prevention counseling
- STD treatment
- HIV education and risk reduction
- Medical services for HIV-infected clients
- Partner interviewing and notification for Syphilis, Gonorrhea, Chlamydia, and HIV
- Data Management for HIV testing and STD
- Communicable Disease Specialists partner with physicians, hospitals, and laboratories in the private sector to enhance reporting and give new treatment information
- Syphilis Elimination, Infertility, Corrections, and Perinatal special projects

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is a federal program that provides primary care and support services for people living with HIV infection who lack health insurance and are financially

unable to pay for HIV/AIDS care. Ryan White Title I gives grants to 51 Eligible Metropolitan Areas (EMAs) in the United States for people who are disproportionately affected by HIV/AIDS. Ryan White Title III provides grants and planning for comprehensive primary health care and health care delivery for people infected with HIV/AIDS.

The STD/HIV Section is the Grantee for Ryan White Title II and IV funds in Georgia. Ryan White Title II services may include home and community-based health care and support services. Ryan White Title II services also include the Health Insurance Continuation Program (HICP), AIDS Drug Assistance Program (ADAP), local consortia, and Direct Health and Support Services. ADAP provides medications approved by the FDA to HIV positive people who are low income and receive limited or no health insurance from private sources or Medicaid.

Of the 4,703 ADAP clients served in 2001, 1,534 were white, 2,976 were African-American, 170 were Hispanic/Latino, 14 were Asian/Pacific Islander, 2 were American Indian/Alaska Native, and 7 were of unknown race/ethnicity. Primary care and support services for people living with HIV and AIDS are provided in 17 out of 19 health districts in Georgia through funding from the STD/HIV Program. A Title II Consortium is in each district to serve as a planning and advisory group for Georgia. The purpose of the local consortia is to have a service delivery system that is comprehensive and coordinated. The following are the primary care and support services that are provided:

- Ambulatory/outpatient medical care
- Non-ADAP medications
- Case management
- Dental care
- Substance abuse/Mental health counseling
- Outreach to HIV positive persons
- Support services, i.e., transportation, nutritional services

Ryan White Title IV coordinates HIV services and access to community and family oriented care for children, youth, women, and families. The two projects for Ryan White Title IV are located in metropolitan Atlanta and in the Waycross region of the state.

Community Planning is a continuous process by the State of Georgia's STD/HIV Program, along with other state and local agencies, community organizations, and advocates for people who are at risk for HIV infection to develop a



comprehensive HIV prevention plan for Georgia. The forty-member Community Planning Council sets HIV Prevention priorities by analyzing the HIV/AIDS epidemic, available prevention sources, unmet HIV Prevention needs, high-risk behaviors for HIV, strategic impact, and the evaluation of the community planning process.

The Community Planning Council identifies target groups and funds community organizations through Request for Proposals (RFPs) to serve these high-risk populations.

Office of Adolescent Health and Youth Development/ Georgia Division of Public Health

The purpose of the Adolescent Health and Youth Development (AHYD) program in the Georgia Division of Public Health (DPH), Georgia Department of Human Resources (DHR) is to increase and expand the skills and health status of adolescents in Georgia by providing services through programs that involve collaboration with families, communities, schools, and other public and private organizations. These programs target youth 10 to 19 years old. The AHYD sponsors programs that strengthen positive attitudes, encourage healthy behaviors, and reduce high-risk behaviors such as violence, substance abuse, low achievement in schools, and sexual activity. There are 39 Comprehensive Adolescent Health Centers that are located in 34 counties in Georgia. The centers are located in communities with the greatest need for risk prevention and risk reduction identified by the federally approved "Indicators of Youth Risk Behavior".

The Office of Adolescent Health and Youth Development provided the following assistance to adolescents in Georgia in FY 2001:

- Comprehensive health services: (115,650); education (102,189); and counseling (32,634)
- Community involvement: 55,689
- Male involvement: 4,538
- Abstinence-only education: 51,378

Office of Rural Health/Georgia Department of Community Health

In 1990, the Georgia Farm Workers Health Program (GFHP) was established for migrant and seasonal farm workers (MSFWs) and their families. This program was created to improve the overall health status of this population.

A migrant farm worker is a person who works seasonally in agriculture and establishes a temporary residence in this employment.

A seasonal farm worker is employed seasonally in agriculture, but does not setup a temporary home.

According to the 1997 United States Department of Labor's *National Agriculture Workers Survey*, 70% of MSFWs in the United States were born in a foreign country, two-thirds were under the age of thirty-five, and two-thirds were male. Of the MSFWs who were foreign born, 94% were Mexican, 5% were from other Latin American countries, and the rest were workers from countries such as the Philippines, Southeast Asia, Haiti, and English-speaking Caribbean islands.

In 1995, the Institute of Community and Area Development (ICAD), University of Georgia conducted a survey. This survey, *Migrant and Seasonal Farmworkers in Georgia: Estimates of the Migrant Health Program Target Population*, estimated that the number of migrant and seasonal farm workers (MSFWs) and their dependents would surpass 125,000 and the number of MSFWs and their dependents served by the Georgia Farm Workers Health Program (GFHP) would exceed 75,000.

The GFHP has six projects sites in 21 rural counties in Georgia and provides primary health care such as diagnosis and treatment of illness, preventive health services, outreach services, case management, and health education. HIV testing is provided to migrant and seasonal workers. HIV prevention and care are provided through health fairs, health education and training, and case management.



Minority Community-Based Organizations' Technical Assistance Survey

The goal of the Office of Minority Health/Georgia Department of Community Health's HIV/AIDS project is to reduce the burden of HIV infection among minorities by providing minority-specific epidemiological data, access to resources, capacity-building, technical assistance, and linkage building to minority community-based organizations (MCBOs) in the State of Georgia. The Georgia HIV/AIDS Project in the Office of Minority Health provides technical assistance activities for minority community-based organizations as a part of the State and Territorial HIV/AIDS demonstration program. This grant facilitates the capacity of the State Office of Minority Health to identify areas of need; link minority community-based organizations (MCBOs) with partners in response to these areas of need; and facilitate access to federal technical assistance.

A survey of 50 minority community-based organizations (MCBOs) was conducted throughout Georgia for the HIV/AIDS Project from August 2000 to October 2001. These minority organizations included nonprofit and faith-based organizations. The purpose of this survey was to identify the target populations of these organizations, program development needs, access and barriers to federal funding, collaborations with other organizations, and technical assistance needs. It should be noted that the organizations surveyed represented a sample of organizations that were linked to the Georgia Office of Minority Health's HIV/AIDS Project. The survey data were collected by phone, fax, and personal interviews.

Each organization surveyed had one or more target population. The organizations surveyed targeted African-Americans, women, substance abusers, pediatrics/children, Hispanics/Latinos, men who have sex with men (MSM), rural populations, and the incarcerated. Of the 50 organizations, 14% targeted American Indians/Alaska Natives and 18% targeted Asians/Pacific Islanders.

The type of HIV/AIDS activities provided by the organizations included prevention education, educa-

tional and outreach materials, needle exchange, housing, case management, HIV testing, counseling, treatment, and referrals.

Sixty-seven percent of MCBOs surveyed applied for HIV/AIDS funding from the federal government. The following reasons were given by MCBOs for the funding agency not accepting a proposal: no follow-up, untimely submission, and inefficient infrastructure.

The following were listed as barriers for MCBOs in applying for federal funding:

- Application process was difficult
- Lack of awareness and knowledge of funding
- Grant writing skills
- Time to complete the application
- Infrastructure
- Technical assistance needed
- Overwhelmed staff
- Competition of funds from larger organizations
- Apathy and stigma of the HIV/AIDS epidemic

MCBOs were asked if they collaborated with any organizations that were federally funded.

MCBOs collaborated with other organizations because they needed the resources, worked with the same population, had a history of working together, collaboration was encouraged by funders, and other organizations had more expertise.

The main barriers to collaborating with federally funded MCBOs were competition and turf issues, lack of expertise, other organizations did not want to collaborate, no time to develop working relationships, and geographical location.

The most requested technical assistance needs were how to complete a federal grant application, how to evaluate your program, federal grant financial reporting requirements, and managing federal grant dollars/budgeting.



Issues and Concerns

The cost of HIV/AIDS

Effective medications and preventive care have given people living with HIV/AIDS an improvement in the quality of life, less hospital time, and a longer life. The majority of new HIV/AIDS cases in Georgia are among African-Americans. The number of HIV/AIDS cases among other minorities such as Hispanics/Latinos, Asians/Pacific Islanders, and American Indians/Alaska Natives in Georgia is small compared to African-Americans and whites. However, AIDS Surveillance data and other sources show that their number, although small, may be increasing in some areas of the state. Minority persons living with HIV/AIDS are more likely to be in poverty, underinsured, and use public health care facilities.

Through the Georgia AIDS Drug Assistance Program (ADAP), the cost of 3 or 4 medications for people living with HIV or AIDS is nearly \$10,000 per year. Of the 4,703 ADAP clients served in 2001, 63% were African-American, 33% were white, 4% were Hispanic/Latino, <1% were Asian/Pacific Islander, and <1% were American Indian/Alaska Native.

Medicaid is a health insurance program that is supported by states and the federal government. Medicaid supports low-income and other disadvantaged people such as the disabled. In the State of Georgia, Medicaid is administered through the Georgia Department of Community Health/Division of Medical Assistance (DMA). In FY 2001, the state spent \$60 million on Medicaid recipients with HIV. Of the total costs, \$45,099,943 (74%) was for African-American recipients.

The Division of Medical Assistance (DMA) in the Georgia Department of Community Health and the Division of Public Health (DPH) in the Georgia Department of Human Resources submitted a joint application to the United States Department of Health and Human Services/Health Care Financing Administration in October 2000 for an HIV waiver. This waiver is currently pending and would allow people with HIV/AIDS who do not currently qualify to receive Medicaid insurance.

Therefore, maintaining and increasing public assistance for HIV/AIDS care is important for minority persons living with HIV and AIDS. This would enable them to live as long as possible while sustaining a healthy life style.

Barriers to HIV prevention and care among American Indians/Alaska Natives, Asians/Pacific Islanders, and Hispanics/Latinos

American Indians/Alaska Natives were the original inhabitants of Georgia. The history of American Indians/Alaska Natives in the United States includes forced removal from their territories, colonization, and prohibition of cultural traditions¹⁴. As of result, there is a distrust of the government and public health institutions and programs. American Indians/Alaska Natives are <1% of the population in Georgia. Through December 2001, there were 15 AIDS cases reported in Georgia among American Indians/Alaska Natives and 10 are living with AIDS in Georgia. This group may be perceived to be at low risk for HIV infection. However, American Indians/Alaska Natives are disproportionately affected by risk factors associated with HIV such as poverty, poor health, domestic violence, and substance abuse¹⁴.

Asians/Pacific Islanders are a diverse racial and ethnic group that is growing rapidly in the state. The lack of attention in preventing HIV among Asians/Pacific Islanders in Georgia may include cultural and language barriers, lack of HIV/AIDS data, and lack of culturally appropriate resources. There are over 200,000 Asians and Native Hawaiians and other Pacific Islanders in Georgia, which represent 2% of the population. There were 46 AIDS cases reported among Asians/Pacific Islanders in Georgia and 25 Asians/PI are living with AIDS as of December 2001. This may be the result of underreporting and lack of HIV testing. Furthermore, this group may be perceived to be at low risk for HIV infection. However, the number of cases reported among Asians/Pacific Islanders increased from 4 in 2000 to 7 in 2001. According to recent data, various countries in Asia are reporting epidemic proportions of HIV/AIDS. Given this fact and the immigration and migration patterns of Asians and Pacific Islanders into the United States, HIV prevention for this group should be given more serious consideration.

Hispanics/Latinos in Georgia are 5% of the population. According to AIDS Surveillance data, Hispanics are 3% of the 11,395 people living with AIDS as of 2001. The number of AIDS cases reported in Hispanics has increased recently in Georgia. At HIV Counseling and Testing sites in 2001, 1,951 tests were positive for HIV and 86 or 4% of the positive tests were from Hispanics.



The Hispanic population is increasing rapidly in Georgia. The unavailability of bilingual interpreters and illiteracy can hinder Hispanics and Latinos from understanding health information and health concerns. Complacency, stigma, misconceptions about HIV/AIDS, and lack of education are other barriers to informing Hispanics of HIV/AIDS. Cultural sensitivity and ethics of service providers can prevent Hispanics/Latinos from either getting tested or seeking HIV treatment, along with economic issues and transportation. Many migrant and seasonal workers are young, Hispanic, and male. The Georgia Office of Rural Health provides HIV prevention and services through its Georgia Farm Workers Health Program (GFHP). These workers may be susceptible to HIV because of high-risk behaviors during their temporary employment.

Abstinence-based sex education and AIDS education policy in Georgia schools

The percent of reported AIDS cases among minorities by age groups in Georgia was 45% among persons 30-39 years of age, followed by 25% among people 40-49 years old, 20% among persons ages 20-29, 9% among persons 50 years old and older, and 1% among adolescents 13-19 years old. People who were diagnosed with AIDS have lived with HIV on the average of at least ten years. Knowledge of sexually transmitted diseases among adolescents and teenage pregnancy rates are valuable tools in assessing the risk for HIV infection among young people because they demonstrate risk behaviors associated with HIV infection. Sexually transmitted diseases increase the risk of HIV infection because of increased susceptibility and contagiousness. People 19 years old and younger had the highest number of chlamydia cases in Georgia in 2001 and the second highest number of gonorrhea cases. Georgia was the eighth highest in the number of teenagers who gave birth in 2001 in the United States; however the birth rate for teenagers 15 - 19 declined 19% from 1990 to 2001 in Georgia. The teen pregnancy rate for African-American females 15 - 19 years old in 2000 was 110.2 per 1,000 and 70.2 per 1,000 for white females 15 - 19 years old. The Georgia State School Board's policy on sex education and AIDS education instruction in school systems emphasizes abstinence from sexual activity until marriage and fidelity in marriage.



Policy Recommendations

Develop a complete HIV/AIDS Surveillance system

Georgia should establish a name-based surveillance system for HIV. Georgia does not currently have an HIV Surveillance system. Georgia has an AIDS Surveillance system. AIDS cases are reported by public and private health care providers on a HIV/AIDS reporting form that identifies demographic information, including the name of the patient, facility of diagnosis, mode of HIV transmission, and AIDS-related lab and clinical information. AIDS Surveillance data show risk factors of individuals with AIDS who may have acquired HIV many years prior to the AIDS diagnosis. Of all AIDS cases reported in Georgia from 1981 – 2001, 65% (n= 15,930) were among minorities; furthermore, in recent years, the proportion has increased (82% in 2001). In 2001, HIV Counseling and Testing data showed that of the 82,031 tests performed at approximately 400 testing sites in Georgia, 1,951 or 2.4% were positive for HIV. Of the 1,951 tests that were positive, 79% were among African-Americans, 16% were among whites, 4% were among Hispanics/Latinos, <1% were among Asians/Pacific Islanders, <1% were among American Indians/Alaska Natives, and <1% were among people of other ethnicities. However, HIV Counseling and Testing is a small part in understanding the HIV epidemic in Georgia because the testing sites are located at public health or publicly funded facilities and does not include individuals testing at private physicians' offices. Instituting a surveillance system that includes HIV and AIDS cases in Georgia will intensify HIV prevention efforts by ensuring a complete understanding of the HIV/AIDS epidemic.

Increase collaborations among state agencies and community organizations

Collaboration among public health and community health agencies and minority community-based organizations through memorandums of agreements (MOA) or other partnerships can greatly expand HIV prevention and medical care for minorities living with HIV/AIDS in Georgia. The use of minority-specific HIV/AIDS data has been profoundly increased in Georgia, due primarily to the Georgia Office of Minority Health's HIV/AIDS demonstration grant, that includes collaboration with staff from OMH and the Epidemiology Branch in the Georgia Division of Public Health. MCBOs benefited from this collaboration by having increased capacity to compete for and implement HIV prevention programs. Additional databases with minority-specific data should be accessed, and future publications should link data output with policy. Collaboration with community-based organizations can also provide a greater understanding of hard to reach populations such as rural populations, migrant and seasonal farm workers, the homeless, the incarcerated, Hispanics/Latinos, Asians/Pacific Islanders, and American Indians/Alaska Natives. These populations may be at risk for HIV infection because of stigma and discrimination, stereotyping of who gets HIV, and access to health care. Increased knowledge, awareness, and support of HIV/AIDS programs and activities in state agencies among state employees and community organizations are needed to maintain HIV/AIDS prevention, treatment, and care for all Georgians.



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